COUNTY OF LOS ANGELES
Public Health

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June 14, 2016

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

AUTHORIZATION TO ACCEPT AND SIGN A FORTHCOMING AGREEMENT AND AMENDMENTS FROM THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, AND APPROVE POSITIONS TO SUPPORT THE DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Provide authorization to accept and sign a forthcoming agreement and amendments from the California Department of Health Care Services, and approve interim ordinance authority to add and fill 49 positions to implement and perform the required activities and functions of the Drug Medi-Cal Organized Delivery System Waiver.

IT IS RECOMMENDED THAT THE BOARD:

1. Delegate authority to the Interim Director of the Department of Public Health (DPH), or her designee, to accept and sign an agreement to be received from the California Department of Health Care Services (State) after the Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 Medi-Cal 2020 Research and Demonstration Waiver (Waiver) implementation plan has been approved, subject to review and approval by County Counsel, and notification to your Board and the Chief Executive Office (CEO).

2. Delegate authority to the Interim Director of DPH, or her designee, to accept amendments that are consistent with the requirements of the forthcoming agreement referenced above that reflect non-material and/or ministerial revisions to the terms and conditions of the DMC-ODS Waiver or the agreement, subject to review and approval by Count Counsel, and notification to your Board and the CEO.

3. Approve interim ordinance authority, pursuant to Section 6.06.020 of the County Code, for 49 new full-time permanent positions, as detailed in Attachment A, in DPH, subject to allocation by the CEO, Classifications and Administrations. These positions are 100 percent funded by State Realignment funds.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Approval of Recommendation 1 will allow DPH to accept a forthcoming agreement to support DMC-ODS Waiver services upon final approval of the County's DMC-ODS Waiver implementation plan (Exhibit I) by the State and the federal Centers for Medicare and Medicaid Services' (CMS).

Background on the DMC-ODS Waiver

On February 11, 2016, DPH Substance Abuse Prevention and Control (SAPC) submitted Los Angeles County's (County) DMC-ODS implementation plan to the State. On March 11, 2016, County received comments from both the State and CMS on the plan. On April 6, 2016, a final draft of the implementation plan addressing all comments was submitted to the State and CMS.

The DMC-ODS will transform the current substance use disorder (SUD) system from a contract administration program to a specialty managed care program for SUD treatment, similar in form and function to the County's Mental Health Plan operated by the Department of Mental Health. The transformation to a specialty health care plan will expand reimbursable DMC services to include case management, medication-assisted treatment, recovery support services, residential treatment, and withdrawal management for all Medi-Cal eligible recipients. At the present time, a limited scope of DMC services are reimbursable for Medi-Cal recipients. For example, residential treatment services are reimbursable for pregnant women only.

The expanded DMC-ODS services will be evidence-based and use the American Society of Addiction Medicine (ASAM) criteria to determine medical necessity and appropriate level of care. Additionally, the DMC-ODS will enhance care coordination with other service delivery systems, including physical and mental health and social services, and increase local control and accountability to improve standards, quality of care, and outcomes across the entire delivery system.

Upon the State and CMS's final approval of SAPC's implementation plan, SAPC will have one (1) year to fully execute the terms and conditions of the DMC-ODS Waiver.

Approval of Recommendation 2 will allow DPH to accept amendments that are consistent with the requirements of the forthcoming agreement that reflect non-material and/or ministerial revisions to the terms and conditions of the DMC-ODS Waiver.

Approval of Recommendation 3 will allow DPH to immediately add and fill SAPC and Antelope Valley Rehabilitation Center (AVRC) positions to begin setting the foundation to implement and perform the managed care responsibilities required to enroll the first patients in the DMC-ODS Waiver by the anticipated start date of July 2017.

Transforming SAPC from a SUD contract management entity into a SUD managed care entity will require a significant shift in responsibility and restructuring of the SUD system of care. Most notably, within the new DMC-ODS managed care environment, SAPC will need additional clinical and network planning and development staff to build a high-quality organized delivery system based on

required utilization review procedures, performance and outcome measures, and timely access to all levels of care that are aligned with managed care principles and regulations.

The usage of ASAM criteria is a requirement of the DMC-ODS. The ASAM criteria provide a comprehensive and multidimensional assessment of health needs to establish medical necessity and appropriate level of care for patients. The systemwide implementation of the ASAM criteria will require a major shift from existing practices among contracted provider agencies. This newly standardized framework for clinical decision-making will require SAPC to verify medical necessity and demonstrate that services are clinically appropriate to address each patient's treatment needs. SAPC's newly created Quality Improvement/Utilization Management Unit will conduct reviews of medical necessity and will be required to authorize residential treatment services within 24-hours. This unit will also develop clinical standards that align with the ASAM criteria, train providers on all required clinical standards, and monitor all contract providers to ensure the clinical standards are maintained at the highest possible level.

DMC-ODS SUD services will initially be delivered through SAPC's existing contracted providers, a group of 170 contractors providing services at more than 620 sites geographically dispersed throughout the County. To implement the DMC-ODS Waiver at a scale appropriate for Los Angeles County by July 1, 2017, additional providers must be certified and licensed to maximize revenues for the expanded treatment services. New Master Agreements with qualified providers will be presented by July 1, 2017 to your Board for approval prior to execution. The additional clinical staff being requested in Recommendation 3 will manage and coordinate client care within the newly expanded DMC-ODS managed care network, including care coordination with the physical and mental health system.

Becoming a managed care entity will also necessitate new network planning staff to inform and steer policy decisions within the new landscape established by the DMC-ODS Waiver. Staff with robust strategic, policy, analytic, and managed care planning capabilities will be necessary to develop a new and evolving delivery system, in addition to piloting new payment methodologies that will ensure timely access to new SUD services and performance incentives tied to treatment outcomes. Finally, staff will also need to provide training and technical assistance to contracted agencies to prepare them to effectively deliver the expanded DMC services within a new managed care environment. These are functions that the current SAPC staff is not currently performing.

Implementation of Strategic Plan Goals

Recommended actions support Goal 1, Operational Effectiveness/Fiscal Sustainability, Goal 2, Community Support and Responsiveness; and Goal 3, Integrated Services Delivery, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The DMC-ODS Waiver will provide substantial financial support for expanded SUD services. Under the financing available through the Affordable Care Act (ACA), the federal share of costs for Medi-Cal beneficiaries who became newly eligible through the ACA in 2014 will be 100 percent through 2016, decrease incrementally to 90 percent by 2020, and remain at that level thereafter. The County will continue to be responsible for 50 percent of the cost for beneficiaries who were eligible prior to the ACA's Medi-Cal expansion. Beginning July 1, 2017 non-federal SUD funding streams will be used to draw down the maximum federal Medi-Cal matching funds to support the expanded SUD services available to all Medi-Cal beneficiaries under the DMC-ODS Waiver.

It is anticipated that the expanded DMC-ODS services in Los Angeles County will not require any additional net County cost, as existing funding streams and the County's ability to draw down the maximum federal Medi-Cal matching funds will be sufficient to provide the full continuum of SUD services.

The projected annual salary and employee benefit costs of the 49 budgeted positions for SAPC and AVRC will be supported by Realignment funds until June 30, 2017, and by the new DMC-ODS Waiver funds beginning July 1, 2017.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On August 13, 2015, the State received approval from the federal CMS to amend its section 1115 demonstration project to include additional benefits and federal/State funding to establish a fuller continuum of SUD services for Medi-Cal eligible beneficiaries.

On January 21, 2015, DPH informed your Board that SAPC submitted to the State a County Expression of Interest to participate in the DMC-ODS Waiver demonstration project.

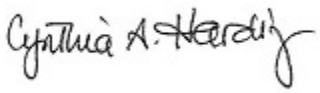
On February 11, 2016, SAPC submitted its County implementation plan to the State.

By participating in the DMC-ODS demonstration project, SAPC must operate as a federally-designated "prepaid inpatient health plan" in compliance with the Code of Federal Regulations Section 42, Part 438 (42 CFR Part 438). This requires SAPC to conduct a continuous quality assessment and performance improvement program, participate in an external quality review process, and establish a patient appeals and grievance process. None of these responsibilities are currently required of SAPC.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

The range of new SUD services that will result from implementing the DMC-ODS Waiver significantly advances the potential for positive patient health outcomes and for producing overall cost savings to the safety net health care delivery system, particularly with greater service coordination and integration with physical and mental health care. Most importantly, enhanced service quality will improve the quality of life for patients, their families, and the communities in which they live.

Respectfully submitted,



Cynthia A. Harding, M.P.H.
Interim Director

CAH:nb
BL#03639

Enclosures

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors

ATTACHMENT A

SUBSTANCE ABUSE PREVENTION AND CONTROL AND ANTELOPE VALLEY REHABILITATION CENTER

POSITION REQUEST

FY 2016-17

Program	Item #	Classification	# of Positions
Substance Abuse Prevention and Control (SAPC)			
Office of Medical Director and Science Officer	5458A-79	Chief Physician II, Psychiatry	1
	5472J	Consulting Specialist, M.D.	1
	2102A	Senior Secretary III	1
	0889A	Administrative Assistant III	1
Research, Epidemiology, and Evaluation	2095A	Secretary II	1
	4573A	Chief, Public Health Records and Research	1
Epidemiology	8973N	Research Analyst III, B.S	1
Evaluation	8974A	Chief Research Analyst, B.S.	1
Research	8973A	Research Analyst III, B.S.	1
Clinical Standards and Training, and Quality Improvement, and Utilization Manageme	5457A-79	Chief Physician I, Psychiatry	1
Clinical Standards and Training	8712A	Supervising Psychologist	1
	9019A	Senior Clinical Social Worker	1
Quality Improvement, and Utilization Management	8697A	Clinical Psychologist II	1
	8712A	Supervising Psychologist	1
	9019A	Senior Clinical Social Worker	3
	9014A	Clinical Social Work Supervisor I	1
	5280A	Senior Mental Health Counselor, RN	1
	5286A	Nurse Manager	1
	8697A	Clinical Psychologist II	1
	5278A	Mental Health Counselor, RN	3
Policy Strategic Planning and Communications Branch	4542A	Health Program Manager II	1
	2096A	Secretary III	1
Communications	4731A	Health Program Analyst III	1
	4729A	Health Program Analyst II	1
	4727A	Health Program Analyst I	1
	1140A	Senior Clerk	1
Legislative and Policy Analysis	4729A	Health Program Analyst II	2
	4727A	Health Program Analyst I	1
Strategic Planning	4729A	Health Program Analyst II	1
	4727A	Health Program Analyst I	1
	1848A	Management Analyst	1
Substance Use Disorder Managed Care Information System	2526A	Principal Application Developer	1
	2521A	Application Developer II	1
Provider Relations	0750A	Financial Specialist IV	2
Total SAPC			**40**
Antelope Valley Rehabilitation Center (AVRC)	5883A	Substance Abuse Counselor Aides	5
	9035A	Psychiatric Social Worker II	4
Total AVRC			**9**
Total SAPC and AVRC			**49**

EXHIBIT I

START-ODS

SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT

Los Angeles County's Substance Use Disorder Organized Delivery System

The Los Angeles County Department of Public Health, Substance Abuse Prevention and Control

Implementation Plan for Drug Medi-Cal Organized Delivery System Waiver

DRAFT April 5, 2016

County of Los Angeles Public Health
Substance Abuse Prevention and Control

PART I
PLAN QUESTIONS

1. ***Identify the county agencies and other entities involved in developing the county plan. (Check all that apply) Input from stakeholders in the development of the county implementation plan is required; however, all stakeholders listed are not required to participate.***

☒ County Behavioral Health Agency
☒ County Substance Use Disorder Agency
☒ Providers of drug/alcohol treatment services in the community
☒ Representatives of drug/alcohol treatment associations in the community
☒ Physical Health Care Providers
☒ Medi-Cal Managed Care Plans
☒ Federally Qualified Health Centers (FQHCs)
☐ Clients/Client Advocate Groups
☐ County Executive Office
☒ County Public Health
☒ County Social Services
☐ Foster Care Agencies
☒ Law Enforcement
☒ Court
☒ Probation Department
☐ Education
☒ Recovery support service providers (including recovery residences)
☐ Health Information technology stakeholders
☒ Other (specify) Public Defender, Criminal Justice Council

2. ***How was community input collected?***

☒ Community meetings
☒ County advisory groups
☐ Focus groups
☒ Other method(s) (explain briefly): Online survey via SurveyMonkey

3. ***Specify how often entities and impacted community parties will meet during the implementation of this plan to continue ongoing coordination of services and activities.***

☐ Monthly
☐ Bi-monthly
☐ Quarterly
☒ Other/s, specify: about bi-monthly through 2016 and quarterly thereafter

***Review Note*: One box must be checked.**

4. ***Prior to any meetings to discuss the development of this implementation plan, did representatives from SUD, Mental Health (MH) and Physical Health all meet together regularly on other topics, or has preparation for the Waiver been the catalyst for these new meetings?***

☒ SUD, MH, and Physical Health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.

☐ There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver.

☐ There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.

☐ There were no regular meetings previously, but they will occur during implementation.

☐ There were no regular meetings previously, and none are anticipated.

5. ***What services will be available to DMC-ODS clients under this County plan?***

☒ Withdrawal Management (minimum one level)
☒ Residential Services (minimum one level)
☒ Intensive Outpatient
☒ Outpatient
☒ Opioid (Narcotic) Treatment Programs
☒ Recovery Services
☒ Case Management
☒ Physician Consultation

How will these required services be provided?

REQUIRED

☐ All county operated
☒ Some county and some contracted
☐ All contracted.

OPTIONAL

☒ Additional Medication-Assisted Treatment
☐ Partial Hospitalization
☒ Recovery Residences
☐ Other (specify) _____

6. ***Has the county established a toll-free 24/7 number with prevalent languages for prospective clients to call to access DMC-ODS services?***

☒ Yes (required)
☐ No. Plan to establish by: _____

<u>Review Note</u>: If the county is establishing a number, please note the date that it will be established and operational.

7. ***The County will participate in providing data and information to the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs for the DMC-ODS evaluation.***

☒ Yes (required)
☐ No

8. ***The County will comply with all quarterly reporting requirements as contained in the STCs.***

☒ Yes (required)
☐ No

9. ***Each county's Quality Improvement Committee will review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol:***

1. ***Number of days to first DMC-ODS service/follow-up appointments at appropriate level of care after referral and assessment***
2. ***Existence of a 24/7 telephone access line with prevalent non-English language(s)***
3. ***Access to DMC-ODS services with translation services in the prevalent non-English language(s)***
4. ***Number, percentage of denied and time period of authorization requests approved or denied***

☒ Yes (required)
☐ No

PART II
PLAN DESCRIPTION

Narrative Description

1. COLLABORATIVE PROCESS

Describe the collaborative process used to plan DMC-ODS services. Describe how county entities, community parties, and others participated in the development of this plan and how ongoing involvement and effective communication will occur.

Review Note: Stakeholder engagement is required in the development of the implementation plan.

The Department of Public Health (DPH), Substance Abuse Prevention and Control (SAPC) developed a draft of the implementation plan based on what is most needed to advance care for individuals with substance use disorders (SUD), and made it available on the website with distribution by email to contracted providers and other key stakeholders (e.g., County agencies, County Medi-Cal managed care health plans). DPH-SAPC proceeded with conducting a series of stakeholder engagement meetings to ensure adequate opportunities for the public to provide feedback on the draft implementation plan and how it will ultimately be operationalized.

The initial kickoff meeting on August 13, 2015 presented key features of California's DMC-ODS Waiver, the County draft implementation plan, and the process for eliciting stakeholders' feedback. This initial meeting was followed by nine regional meetings conducted between August 19 and September 9, 2015 at locations throughout Los Angeles County that provided a review of the plan and produced feedback on each major section of the plan (Table 1).

Table 1: Regional Stakeholder Meetings

SPA	SD	CITY	FACILITY	DATE
1	5	Lancaster	High Desert Medical Center	August 24, 2015
2	3	Lake View Terrace	Phoenix Houses of Los Angeles	August 31, 2015
3	5	Arcadia	Arcadia Park	September 1, 2015
4	1	Los Angeles	Eagle Rock Library	September 8, 2015
5	4	Marina del Rey	Burton W. Chace Park	September 3, 2015
6	2	Los Angeles	MLK Community Engagement Center	August 19, 2015
				September 9, 2015
7	1	Commerce	Department of Health Services	August 20, 2015
8	2	Gardena	Behavioral Health Services	August 27, 2015
Legend: (SPA) Service Planning Area, (SD) Supervisorial District				

To ensure feedback from County agencies, health plans, and other organizational partners, DPH-SAPC conducted an invitational briefing and feedback session on August 26, 2015 that included representatives from the following entities:

- County Agencies:
  - Department of Children and Family Services (DCFS)
  - Department of Health Services (DHS)
  - Department of Mental Health (DMH)
  - DPH, Office of Strategic Planning
  - DPH, Children's Medical Services
  - Department of Public Social Services (DPSS)
  - District Attorney's Office
  - Probation Department
  - Public Defender's Office
  - Sheriff's Department
- Health Plans:
  - Health Net
  - L.A. Care Health Plan
- Other Entities:
  - California Community Foundation
  - Countywide Criminal Justice Coordination Committee (CCJCC)

An online survey was also developed that allowed stakeholders to provide detailed written feedback about each major section of the plan. Information from the online survey and the regional meetings was compiled and distributed via email to all SUD network contractors and meeting participants, and the implementation plan was updated based on feedback where appropriate. On December 17, 2015, DPH-SAPC held a system-wide meeting to report the results of its stakeholder engagement for the first phase of the feedback process and provided an overview of the major themes, as well as key system transformation efforts that will occur in the next one to three years. Stakeholders could attend in-person or via a real-time webinar. Overall, 88 percent of current SUD treatment providers participated in the stakeholder process held between August and December 2015, in addition to other County partners and interested parties (Table 2):

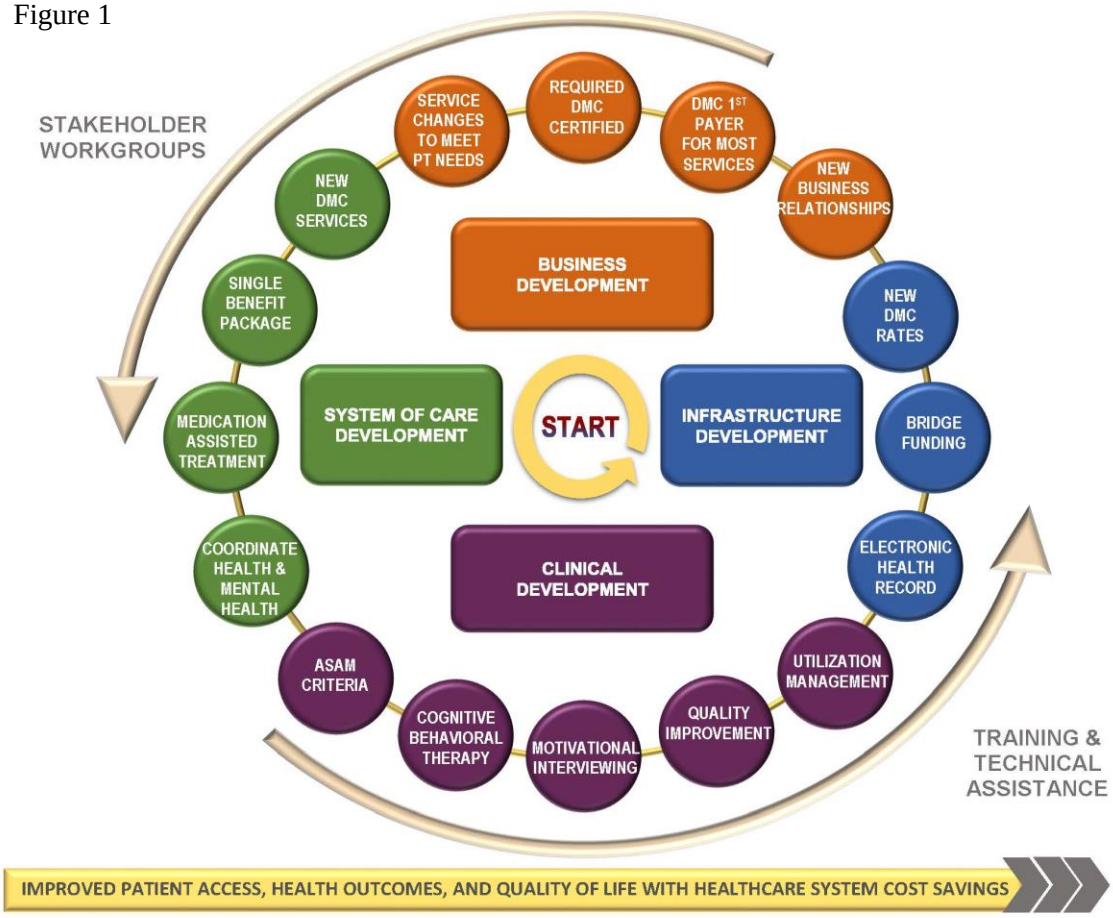
Table 2: Stakeholder Attendance

FEEDBACK TYPE	INDIVIDUALS	AGENCIES
Kick-Off Meeting	98	61
Regional Meetings	107	47
County/Health Plan Meeting	34	13
Online Survey (Complete)	65	60
Online Survey (Incomplete)	25	21
Results Meeting (In-Person)	107	70
Results Meeting (Webinar)	114*	87

* Represents the number of logins only so participation is underrepresented when sharing a viewing station

Submission of the DMC-ODS implementation plan will be the first step in the *System Transformation to Advance Recovery and Treatment of Substance Use Disorders* (START) and initiation of the operational plan to improve clinical care and outcomes. Efforts will occur in four major categories: business development, infrastructure development, clinical development, and system of care development. Stakeholder engagement workgroups, and technical assistance and training, will be central to ensuring development of an effective service system design and the ability to improve patient access, health outcomes, and quality of life with cost savings to the healthcare system overall due to greater investment in quality SUD services (Figure 1).

Figure 1



DPH-SAPC will convene the following anticipated stakeholder engagement workgroups now that the implementation plan has been submitted and these meetings will occur throughout the waiver period, as needed, in order to ensure the system of care is developed, enhanced, and maintained in a manner that supports quality care and improved patient outcomes, and that appropriately incorporates the expertise and perspective of stakeholders to establish a sustainable and effective network of providers.

- *System of Care Development*
  - Youth/Young Adult Services
  - Adult Services
  - Integration of Care

- *Clinical Development*
  - Quality Improvement
  - Utilization Management
- *Business and Infrastructure Development*
  - System Operations
    - Financing
    - Contracts
    - Information Technology
  - System Innovations and Network Capacity Building

These workgroups will be comprised of representatives from various agencies/groups including but not limited to the SUD provider network, the Commission on Alcohol and Other Drugs (County advisory body appointed by the Board of Supervisors), County entities/departments (CCJCC, DCFS, DMH, DHS, DPH, DPSS, Probation, Sheriff's Department, unions), managed care plans (Health Net, L.A. Care), consumer advocacy groups, education, and other interested community members. Information gathered from the previous regional meetings and the online survey will also be used to inform this process, including development of the standards of practice and overall system design. An email listserv was also developed to ensure that the entire SUD provider network, as well as other interested stakeholders, could stay informed about this process even when sending representatives to workgroup meetings is not feasible.

2. PATIENT FLOW

Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, and transitions to another level of care). Describe what entity or entities will conduct ASAM Criteria interviews, how admissions to the recommended level of care will take place, how often clients will be re-assessed, and how they will be transitioned to another level of care accordingly. Include the role of how the case manager will help with the transition through levels of care. Also describe if there will be timelines established for the movement between one level of care to another.

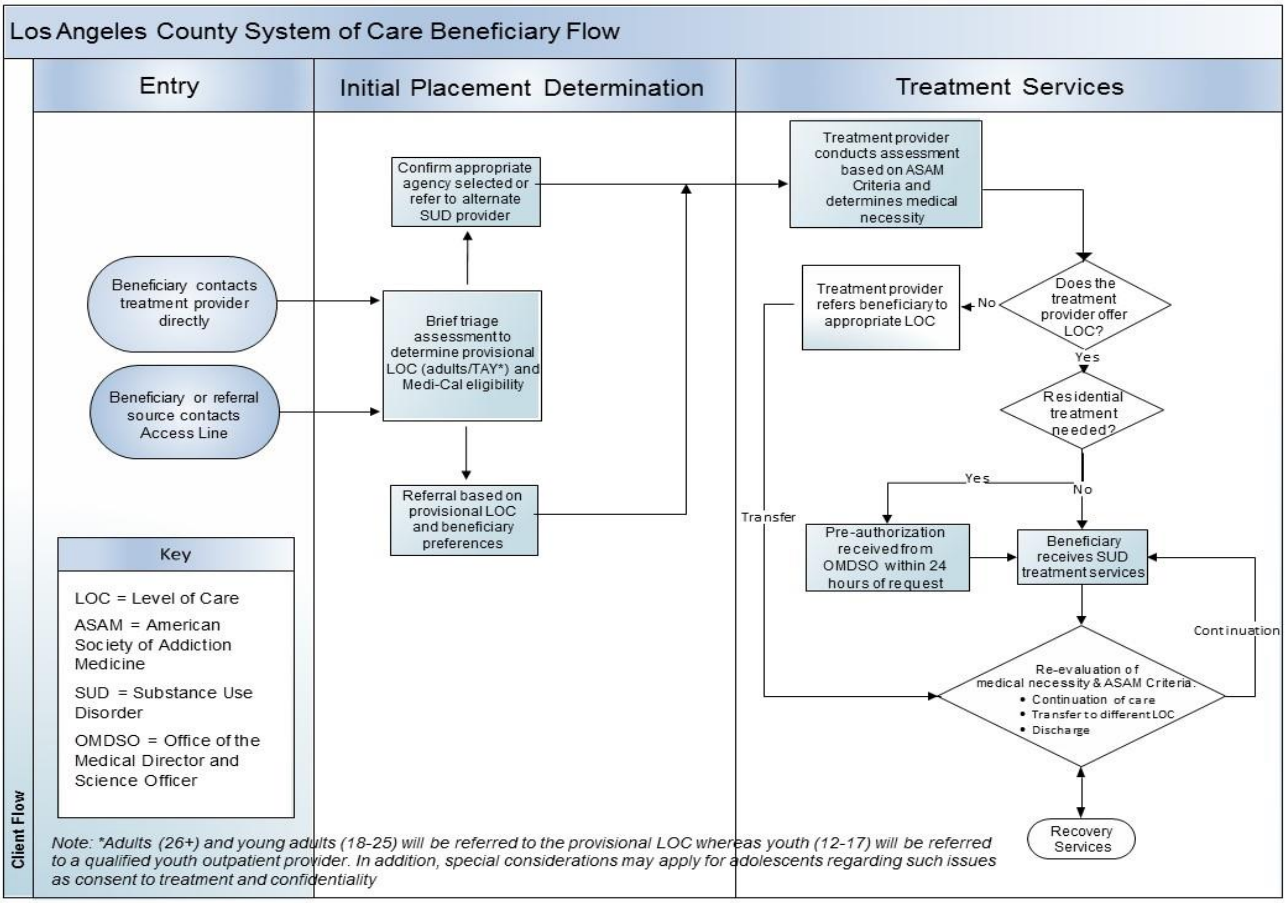
Review Note: A flow chart may be included.

DPH-SAPC operates two systems of care for SUD treatment services: one for adults (18 years of age and older) and one for youth (under 18 years of age). Young adults (18 through 25 years of age) are currently served primarily in the adult system of care, however, to better ensure delivery of developmentally appropriate services, the County intends to expand programs that target this specific age group in year three of the Waiver. Services are delivered through contracts with community-based State-certified and/or licensed SUD treatment programs, and the County-operated Antelope Valley Rehabilitation Centers (AVRC), an outpatient and residential treatment facility for adults. Referrals are accepted from all sources, including County Medi-Cal managed care health plans, other County departments, criminal justice and juvenile justice agencies, child dependency system, community-based human service agencies, employers, schools, families, and self. Services available include the entire range of services contained in the youth and adult benefit packages (Attachment 1). Beneficiaries move through the system of care via the Beneficiary Access Line and the SUD provider network (Figure 2).

There is no "wrong door" to enter SUD services. All individuals seeking admission to SUD services can access them by contacting the toll-free Beneficiary Access Line (see description below) or by contacting any contracted-SUD network provider. At that time, the individual will participate in a brief triage assessment to determine the provisional level of care (LOC) based on the American Society of Addiction Medicine (ASAM) Criteria and Medi-Cal eligibility status. Adults and young adults will be referred to the provisional LOC for further assessment whereas youth will be referred to a qualified youth outpatient treatment agency where they will receive a full assessment and referral to an appropriate higher LOC as necessary. If the individual initially presents at a SUD treatment provider that does not offer the appropriate provisional LOC, that agency will identify alternate referral options in accordance with County requirements to ensure an individual is offered services at the optimal LOC, and assist the individual in connecting with the selected agency; the individual may elect, however, to remain with the initial provider after receiving other referral options (e.g., the individual prefers to receive intensive outpatient services despite qualifying for residential services). All Medi-Cal eligible beneficiaries will be referred to, and/or served by, a DMC certified agency for DMC reimbursable services.

In either case, individuals who need SUD care must be scheduled for an appointment within three business days and receive a face-to-face appointment within 15 business days from the brief triage assessment date; beginning in July 2017 the face-to-face target will be five business days for outpatient and 10 business days for residential LOCs and five business days for all LOCs by July 2018. This approach will allow DPH-SAPC to expand its residential capacity and phase in tighter timeframes for first face-to-face appointment for residential services. At this appointment, the provider will conduct a more intensive biopsychosocial clinical assessment using a standardized tool based on the ASAM Criteria to establish and/or confirm the appropriate LOC placement, and initiate services as indicated. Both the brief triage assessment and the more comprehensive ASAM assessment will be performed by either a certified counselor or Licensed Practitioner of the Healing Arts (LPHA). Given that the brief triage assessment yields only a provisional LOC determination, initial medical necessity will need to be determined at the provider site and an LPHA will need to sign off on the more comprehensive ASAM assessment, if it is performed by a certified counselor. If the initial triage assessment and the fuller ASAM-based assessment to determine medical necessity and the appropriate LOC involve different providers, the initial provider will be responsible for ensuring a "warm hand-off" to support completion of the assessment appointment and enrollment in services.

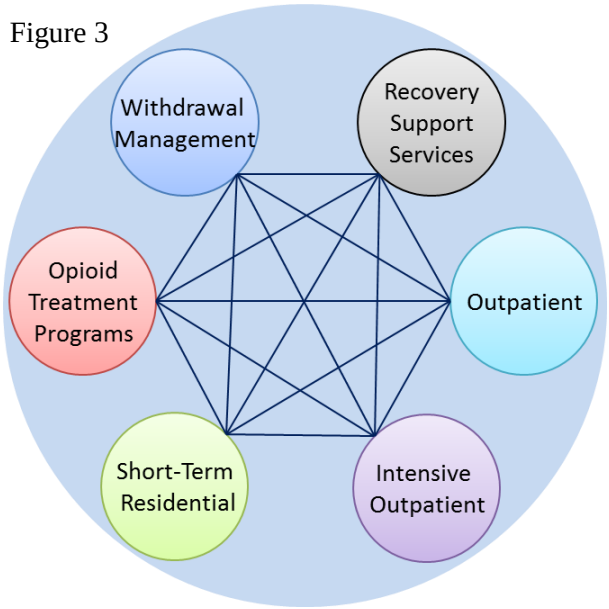
Figure 2



When the brief triage assessment and/or the full ASAM assessment indicates that placement in a residential treatment program (ASAM level 3.1, 3.3, 3.5) is needed, the selected provider will submit a pre-authorization request to DPH-SAPC's Office of the Medical Director and Science Officer, which will conduct a pre-authorization review, and then approve or deny the request within 24 hours of receiving the request. If relapse risk is deemed to be significant without immediate placement in residential care, a County-operated or community-based residential treatment provider may admit an individual prior to receiving residential authorization, with the understanding that authorization denials will result in financial loss (e.g., not billable to other state and federal sources) whereas authorization approvals will be retroactively reimbursed to the date of admission. Pre-authorization by the County is not required for admission into other ASAM LOCs, though it will be required for Medication-Assisted Treatment for those under age 18.

Once admitted into services, an individualized treatment plan will be developed by at minimum a Certified Counselor and signed by an LPHA. To reflect progress, the treatment plan for adolescents and adults will be reviewed, updated, and adjusted accordingly at least every 30-days in all treatment settings, and it is recommended that the treatment plan in more intensive LOCs, such as residential settings, be updated more frequently if an individual is unstable or if there is a notable event that requires a change in the treatment plan. If the individual's condition does not show improvement at a given LOC or with a particular intervention, then a progress review, focused assessment, and treatment plan modification will be made to improve therapeutic outcomes. Should it be determined that the individual requires a change in LOC during the course of treatment, the current treatment provider will assist the individual in transferring to the appropriate LOC within the provider organization or by coordinating a referral to another treatment program with assistance from the Beneficiary Access Line as needed. An individual can move between LOCs, or in some cases be in services concurrently (e.g., residential and opioid treatment programs), as clinically appropriate (Figure 3). Transitions between LOCs will be documented as required by DPH-SAPC to better ensure successful connections with the new service location/provider, including the facilitation of warm hand-offs whenever possible.

Figure 3



Discharge planning between LOCs, during treatment exit, and between systems of care (physical health, mental health, and substance use systems) is an integral component of the treatment process and begins at the time of admission. Processes to prepare the individual for return or reentry into the community include linkages to essential supportive services such as education, employment training, employment, housing, benefit enrollment, and other human services as indicated at assessment and during the treatment process.

Individuals who completed their episode of treatment, or prematurely exit the SUD system of care, are eligible to receive recovery support services from the last treatment provider of care, which will reengage the individual into treatment if needed.

Case-management and care coordination will be an essential component to ensuring that individuals successfully engage in the initial treatment episode, receive necessary services, and transition through care as clinically appropriate. These services will assist patients in accessing needed medical, educational, social, prevocational, vocational, rehabilitative or other community services, and will be provided by certified counselors and LPHAs. The initial treating provider will be responsible for providing case management services and communicating with the next provider along the continuum of care to ensure smooth transitions between levels of care. Once an individual has successfully admitted for services at the next LOC, the new treating provider

(if a different agency) will assume case-management responsibilities. DPH-SAPC is also in the process of determining its role in providing case management services, as the administrative oversight of its provider network, and is determining how best to coordinate case management with the managed-care health plans, and DHS and/or DMH for those receiving services for co-occurring conditions. A model of case management that is tiered based on risk and/or the level of patient service need (e.g., SUD only versus co-occurring conditions) is being considered and procedures will be finalized before service delivery.

In each case, all beneficiaries, where medical necessity for SUD services has been determined, will have access to case-management and/or care coordination services to assist with admission into SUD services, transitioning from one LOC to another, and navigating the mental health, physical health and social service systems. Treatment provider staff will monitor and track beneficiary progress, coordinate care, and provide linkages with community support services, as well as coordinate referrals to other LOCs. They will also communicate with network providers as beneficiaries move between LOCs and into post-discharge recovery services to support successful transition(s). The County will utilize a risk stratification tool at the Beneficiary Access Line and at provider sites to identify individuals at-risk for high utilization and care transition complications. Individuals stratified into this high-risk group will be offered additional case management support by the County starting in July 2017. In these instances, County case management staff will coordinate with case managers at relevant SUD provider sites and in other systems (e.g., health plans, physical and mental health) to ensure that there is a primary case manager responsible for coordinating an individual's care. In some instances, the primary case manager may be the County case management staff at SAPC. In other instances the primary case manager may be based from a local health plan, DHS or DMH. In this way, case management for this high-risk population will ensure that appropriate levels of care are tailored to individual need within both the SUD and other health systems.

3. BENEFICIARY ACCESS LINE

For the beneficiary toll-free access number, what data will be collected (i.e., measure the number of calls, waiting times, and call abandonment)?

Initially, the Beneficiary Access Line will be operated by the existing Community Assessment Service Centers (CASC) contracted by DPH-SAPC using an existing toll-free line and automated system that routes callers to the nearest of 19 CASC sites located throughout the County. The line will be answered by a live CASC staff person on weekdays from at minimum 8 AM to 6 PM, with calls forwarded to a live staff at the Los Angeles County's health and social services information referral line (211 LA County) after hours, and on weekends and holidays. Both lines will have appropriate technology (i.e., TTY) to be able to effectively work with individuals with hearing impairments. Services will be offered in English and Spanish, and a translation service will be immediately available for all other threshold languages.

At a minimum, certified substance abuse counselors will conduct screening interviews with callers or those seeking services in-person using the standardized adolescent or adult brief triage assessment based on the ASAM Criteria, make a provisional LOC determination, identify Medi-

Cal eligibility, and schedule an assessment/admission appointment with a network provider; in the interim. DPH-SAPC is developing an automated system (target completion date July 2017) to identify available treatment slots/beds in the community and schedule assessment/admission appointments at a location that provides the provisional LOC recommended by the brief triage assessment and aligns with other patient preferences/needs. This system should streamline the patient's entry into the system of care, and better ensure receipt of culturally, linguistically, and developmentally appropriate services. In the interim, however, the CASC will identify the treatment provider via the phone to schedule the assessment and admission appointment availability.

Appointments will be scheduled with the selected provider while the caller is on the line whenever possible, but no later than three business days, and tracked according to DPH-SAPC requirements. A reminder and follow-up process will be established in accordance with "warm hand-off" procedures to better ensure that beneficiaries attend the assessment/admission appointment. In these instances, the initial provider will be responsible for actively transitioning a patient to the subsequent provider, as consistent with the "warm hand-off" model, and will be responsible for following up with the patient to ensure that he/she attended the assessment/ admission appointment. Once this has been confirmed, the responsibility for the patient is transitioned to the subsequent provider. All access line procedures will be conducted with the individual as a full participant in the decision-making process, including offering referral options that align with geographic, service hour availability, cultural, and other preferences.

The following information will be collected by the Beneficiary Access Line for continuous quality improvement purposes:

- Number of calls received by day and time blocks;
- Rate of call abandonment;
- Rate of unanswered calls;
- Number of brief triage assessments conducted;
- Number of referrals to treatment by LOC;
- Number of days from initial call/contact to assessment/admission appointment;
- Number of individuals who attended assessment/admission appointment;
- Analysis of wait time to treatment enrollment;
- Demographic characteristics of callers (age, gender, ethnicity/race, primary language if non-English speaking, ZIP Code of residence); and
- Insurance status by health plan (e.g., L.A. Care, Health Net) and funding source (e.g., DMC).

DPH-SAPC is presently considering various options for how the Beneficiary Access Line is operated long-term, including continuing the use of CASCs, a County-operated service (e.g., adding functionality and capacity to an existing DMH line), or contracting with an independent entity for this service. Experiences within the first year of DMC-ODS plan implementation will inform decisions on how to permanently staff and operate the 24/7 call-line, and a permanent solution should be determined within year two of the Waiver. In the interim and due to 211's staffing structure, a brief triage assessment will not be conducted between the hours of 6 PM and 8 AM, and on weekends/holidays but appropriate referrals will be made.

4. TREATMENT SERVICES

Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional medication assisted treatment, recovery residences) to be provided. What barriers, if any, does the county have with the required service levels? Describe how the county plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out county.

Review Note: Include in each description the corresponding ASAM level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the waiver implementation date.

The County will implement an initial benefit package of SUD services within the initial 12 months of execution of the new State and County contract (Table 3, Attachment 1). For adolescents this will include ASAM LOCs 1, 2.1, 3.1 and 3.5; for adults this will include ASAM LOCs 1, 2.1, 3.1, 3.3, 3.5, 1-WM, 3.2-WM, and 1-OTP as well as medication-assisted treatment. Medication-assisted treatment will be available to youth on a case-by-case basis depending on clinical need, and case-management/care coordination, recovery support, and physician consultation services will be available to all beneficiaries served within the DPH-SAPC system of care. By year three, ASAM LOC 2-WM will be added to the benefit package for adults.

Several LOCs are funded outside of the SUD system of care (ASAM 0.5, 2.5, 3.7 and 4.0); however, DPH-SAPC and its network of providers will coordinate referrals where needed to better ensure delivery of services that best match the beneficiaries' level of need. A Memorandum of Understanding with the Medi-Cal Managed Care plans in Los Angeles County (LA Care and Health Net) will delineate and facilitate this cross-system referral process. Beneficiaries who are transitioning from ASAM levels 3.7 and 4.0 will be referred to the Beneficiary Access Line to initiate entry into the SUD system of care. As is the case for all individuals who contact the Beneficiary Access Line, those transitioning from ASAM levels 3.7 and 4.0 will be stratified according to risk (see Section 2, Patient Flow) and referred to a provisional LOC as determined by the brief triage assessment. Given the crucial transition period between an inpatient hospital and community-based setting, every effort will be made to ensure a "warm hand-off" to better enable these beneficiaries to attend the assessment/ admission appointment. The transition into ASAM levels 3.7 and 4.0 is equally critical and will be facilitated by the Beneficiary Access line if it is determined that an individual requires that LOC. SAPC will actively engage hospitals in Los Angeles County and their provider associations to provide information and materials describing the resources of the expanded substance use disorder benefits package and the delivery system transformation. Outreach activities will emphasize the role of the Beneficiary Access Line in facilitating referrals between inpatient levels of care and emergency departments and SAPC's delivery system.

DPH-SAPC-Funded LOC Descriptions

Outpatient Services (ASAM Level 1.0): Services are provided by a DHCS-certified outpatient facility and consist of counseling for up to nine hours per week for adults and up to six hours per

week for youth. Services include: intake, assessment, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, medication services, and discharge planning services. Services can be provided in any appropriate setting in the community, including in-person, by telephone, or by telehealth. Medication-Assisted Treatment (MAT) will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC. *Note: As described in Section 18, "Additional Medication-Assisted Treatment," all DPH-SAPC network patients will have access to MAT via the MAT hubs. Unlike with treatment slots and residential bed capacity, MAT capacity at each LOC is not a fixed number and varies depending on caseload and the number of prescribers at the MAT hubs. Efforts will be made to increase appropriate referrals for MAT at all LOCs, and fully utilize and where needed expand, current capacity (see Figure 10).*

Intensive Outpatient Services (ASAM Level 2.0): Services are provided by a DHCS certified intensive outpatient facility and include structured programming provided to beneficiaries for a minimum of nine hours with a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for youth. Services include: intake, assessment, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, safeguarding medications, transportation services, and discharge planning services. Services can be provided in any appropriate setting in the community, including in-person, by telephone, or by telehealth. MAT will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC. *Note: See additional information on MAT capacity under "Outpatient Services" above.*

Low Intensity Residential Services (ASAM Level 3.1): Services are provided by a California Department of Social Services (CDSS) licensed group home facility for youth or a DHCS licensed residential facility for adults each with a DHCS ASAM Level 3.1 designation, and include 24-hour care with at least five hours of clinical services per week. Services include: intake, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, medication services, and discharge planning services. Services are provided primarily in the facility setting. MAT will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC. *Note: See additional information on MAT capacity under "Outpatient Services" above.*

High Intensity Residential Services – Population Specific (ASAM Level 3.3): Services are provided by a DHCS licensed residential facility for adults with a DHCS ASAM Level 3.3 designation, and include 24-hour care for individuals who are unable to successfully function in a more active milieu. Services include: intake, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, medication services, and discharge planning services. Services are provided primarily in the facility setting. This LOC is not available for youth. MAT will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Table 3: SUD Benefit Package and Timeline

Level Of Care (LOC)/Service	ASAM Level	DMC-ODS LOC End Year One		DMC-ODS LOC End Year Three	
		Youth	Adult	Youth	Adult
Early Intervention	0.5	No	No	No	No
Outpatient	1	Yes	Yes	-	-
Intensive Outpatient	2.1	Yes	Yes	-	-
Partial Hospitalization	2.5	No	No	No	No
Low Intensity Residential	3.1	Yes	Yes	-	-
High Intensity Residential Population Specific	3.3	N/A	Yes	N/A	-
High Intensity Residential Non-Population Specific	3.5	Yes	Yes	-	-
Intensive Inpatient Services Medically Monitored	3.7	No	No	No	No
Intensive Inpatient Services Medically Managed	4.0	No	No	No	No
Ambulatory Withdrawal Management Without Extended On-Site Monitoring	1-WM	N/A	Yes	N/A	-
Ambulatory Withdrawal Management With Extended On-Site Monitoring	2-WM	N/A	No	N/A	Yes
Residential Withdrawal Management Clinically Managed	3.2-WM	N/A	Yes	N/A	-
Inpatient Withdrawal Management Clinically Managed	3.7-WM	No	No	No	No
Inpatient Withdrawal Management Medically Managed and Intensive Services	4-WM	No	No	No	No
Opioid Treatment Program	1-OTP	N/A	Yes	N/A	-
Addiction Medications With Concurrent Outpatient/Residential		N/A	Yes	N/A	-
Case Management/Care Coordination		Yes	Yes	-	-
Recovery Support Post Discharge		Yes	Yes	-	-

High Intensity Residential Services – Non-Population Specific (ASAM Level 3.5): Services are provided by a CDSS licensed group home facility for youth with a DHCS residential license or a DHCS licensed residential facility for adults each with a DHCS ASAM Level 3.5 designation, and include 24-hour care for those who are able to successfully function in a more active milieu.

Services include: intake, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, medication services, and discharge planning services. Services are provided primarily in the facility setting. MAT will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Ambulatory Withdrawal Management – No Extended On-Site Monitoring (ASAM Level 1-WM): Services are provided by a DHCS certified outpatient facility with a Detox Certification and a physician/licensed prescriber, and are for individuals with mild withdrawal who require daily or less than daily supervision. Services include: intake, observation, medication services, and discharge planning services. This LOC is generally not available for youth except with DPH-SAPC prior authorization. MAT will be discussed and offered as a referral option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Ambulatory Withdrawal Management – Extended On-Site Monitoring (ASAM Level 2-WM): Services are provided by a DHCS certified outpatient facility with a Detox Certification and a physician/ licensed prescriber, and are for individuals with moderate withdrawal who require all day support and supervision, but who have a supportive family or living situation at night. Services include: intake, observation, medication services, and discharge planning services. This LOC is generally not available for youth except with DPH-SAPC prior authorization. MAT will be discussed and offered as a referral option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Ambulatory Withdrawal Management – Extended On-Site Monitoring (ASAM Level 3.2-WM): Services are provided by a DHCS licensed residential facility with a Detox Certification and a physician/licensed prescriber, and are for individuals with moderate withdrawal who require 24-hour support and supervision. Services include: intake, observation, medication services, and discharge planning services. This LOC is generally not available for youth except with DPH-SAPC prior authorization. MAT will be discussed and offered as a referral option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Opioid Treatment Program (ASAM Level 1-OTP): Services are provided by a DHCS licensed Narcotic Treatment Program (NTP) facility with a physician/licensed prescriber, and are for individuals who require daily or several times weekly opioid agonist medications and counseling to address severe opioid use disorder. Services include: intake, treatment planning, group counseling, individual counseling, patient education, crisis intervention services, collateral services, medication services, medical psychotherapy, and discharge planning services. Specifically, the choice of MAT (e.g., methadone vs. buprenorphine) will be based on a comprehensive clinical assessment by the prescriber at the OTP site and must consider the varied biopsychosocial needs and preferences of each individual case. The County will continue to encourage, through trainings and physician engagement and consultation, diversification of MAT in the OTP setting. The County will also explore having OTPs serve as MAT hubs (see Section 18, Additional Medication-Assisted Treatment). This LOC is generally not available for youth except with DPH-SAPC prior authorization.

Note: For youth, the benefit package is established as a developmentally-appropriate set of services. Not all LOCs or types of services available to adults and young adults are included in the benefit package for youth, such as Withdrawal Management and Medication-Assisted Treatment because these services are generally not approved or appropriate for this population. However, on a case-by-case basis as determined as medically necessary with prior authorization by DPH-SAPC, such services will be made available to youth.

DPH-SAPC Other Service Descriptions

Recovery Support: These services are available to all patients who enter the SUD treatment system, and should be available for a minimum of six months by the last treatment provider of care. The recovery support provider will contact the patient within two business days after discharge from his/her last treatment services to ensure that the individual is receiving necessary support to increase their likelihood of recovery success. The recovery support provider will also be responsible for reengaging the individual in treatment at a later time, if needed. Services include: individual counseling, group counseling, recovery monitoring, and peer-to-peer substance abuse assistance as well as linkages to schools/educational programs, job skills development, support groups, family support, and other ancillary services.

Case-Management/Care Coordination: These services are available to all patients who enter the SUD treatment system, and are available throughout the treatment episode and may be continued during recovery support as allowed by DPH-SAPC. Services include: regular assessment and reassessment to determine need for continued services at the appropriate level, transitions in LOCs, treatment plan development and updates, coordination of referrals (including connections with and transportation to physical and mental health services), monitoring progress in services, and patient advocacy. The County will utilize a risk stratification tool at the Beneficiary Access Line and at provider sites to identify individuals at-risk for high utilization and care transition complications. Individuals stratified into this high-risk group will be offered additional case management support by the County starting in July 2017. In these instances, County case management staff will coordinate with case managers at relevant SUD provider sites and in other systems (e.g., health plans, physical and mental health) to ensure that there is a primary case manager responsible for coordinating an individual's care. The lead case manager (health plan, SAPC, DMH) will be determined based on the individual's primary service need, and ensure that appropriate LOC are tailored to individual need within both the SUD and other health systems.

Recovery Residences: These services are currently available to perinatal and AB 109 patients on a limited basis. The degree to which this can be further expanded, especially to facilitate step-down from residential services, will be determined during year one of implementation. This process includes ensuring adequate quality standards and determining what facility types would be expanded (e.g., National Association of Recovery Residences, Sober Living Network), what criteria would be used to determine patient eligibility, and the degree to which DPH-SAPC would provide funding for specific patients or simply establish a referral network based on determined facility standards. Services would not be provided on-site at recovery residences, but any resident receiving rent support would need to participate in outpatient, intensive outpatient, case-management, and/or recovery support services, as necessary.

Physician Consultation: This includes consultations for DMC physicians with addiction-trained physicians to ensure that SUD providers have access to non-emergency clinical and medical information that can be used to improve care and services for individuals with substance use disorders. These consultations will occur either telephonically or electronically, via the DPH-SAPC website or Electronic Health Record (EHR), and will not occur in real-time. Question topics may include medication-assisted treatments, dosage recommendations, the management of unusual or difficult cases, and LOC recommendations. This service will either be directly operated by DPH-SAPC or subcontracted.

Additional Medication Assisted Treatment: See Section 19 for more information.

Expansion of Services and Barriers to Implementation

A system transformation this extensive will require substantial investment in the clinical, business, and technological infrastructure at both the County- and provider-level, to ensure success of the DMC-ODS pilot and the ability to demonstrate desired outcomes. This infrastructure includes the quality and care coordination standards (e.g., use of the ASAM Criteria, evidence-based practices) that will help improve patient care. Meeting these requirements also comes with additional costs such as hiring and maintaining a well-qualified workforce, providing on-going training and the ensuring fidelity to evidence-based practice models and other standards. Therefore, the reimbursement rates must adequately account for the associated costs to build this improved system of care while also moving it into closer alignment with the mental and physical health systems in accordance with parity. It will also be essential to ensure adequate availability of services, which necessitates expanding the number of providers/service sites (especially residential service sites that also include licensing and zoning requirements) and certifying new agencies and sites in a timely manner. Ensuring adequate reimbursement rates during the negotiation process between the County and State will be critical, as the enhancements and expansion of services outlined within the DMC-ODS pilot will require concomitant financial support.

Cross-County Coordination

In the event that a Medi-Cal beneficiary from another county seeks SUD services that are determined medically necessary but who is not able to receive services directly from that County, DPH-SAPC may provide the services based on those benefits offered by the County of residence and if provided would seek reimbursement from the County of residence at the approved rate, and the County of residence would submit the Certified Public Expenditure claim to draw down federal financial participation.

5. COORDINATION WITH MENTAL HEALTH

How will the county coordinate mental health services for beneficiaries with co-occurring disorders? Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored? Please briefly describe the county structure for delivering SUD and mental health services. When these structures are separate, how is care coordinated?

A current Memorandum of Understanding (MOU) between DPH-SAPC and DMH defines the coordination of mental health and SUD services for Medi-Cal beneficiaries. DPH-SAPC and DMH work closely together to ensure that services are being provided adequately and appropriately for beneficiaries with co-occurring conditions, and will further discuss how to define, improve and ensure care coordination among the health plans, DMH and DPH-SAPC for individuals with physical, mental health, and/or SUD treatment needs. Increasingly, DMH has added DPH-SAPC network providers to its contracted specialty mental health provider network to support an integrated approach to services.

The two County Medi-Cal managed care health plans (Health Net and L.A. Care) are responsible for addressing the mental health services needs of its members with mild to moderate mental health conditions. DPH-SAPC coordinates care with the two County health plans for those with co-occurring SUD and mild to moderate mental health conditions. This relationship is established and defined through MOUs with the two County health plans. DPH-SAPC and the two County health plans are actively assisting the County-contracted SUD network providers to become credentialed by the health plans to provide services for mild to moderate mental health conditions as a means to implement integrated care for this population.

6. COORDINATION WITH PHYSICAL HEALTH

Describe how the counties will coordinate physical health services within the waiver. Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?

In compliance with the DMC-ODS Standard Terms and Conditions, DPH-SAPC is establishing MOUs with the two County Medi-Cal managed care health plans (Health Net and L.A. Care) that define coordination of physical health and SUD services for Medi-Cal beneficiaries (Attachment 2).

DPH-SAPC has already established MOUs with the two County health plans, DHS, DMH, and DPSS for the County's participation in the Cal MediConnect demonstration project for dual Medicare and Medi-Cal beneficiaries. DPH-SAPC, DMH, and the two County health plans will use the care coordination infrastructure established for the Cal MediConnect project to build the DMC-ODS care coordination infrastructure.

The Behavioral Health Steering Committee and Program Administration Team will provide overall policy and programmatic leadership for the coordination of care across physical health, mental health, and SUD service systems. Meetings will be bi-monthly and include leadership from the health plans and County departments. Interdisciplinary care coordination teams comprised of clinical personnel from the health plans and County partners meet regularly to discuss care coordination for beneficiaries with multiple co-occurring conditions. Sharing of patient information is conducted with patient consent in accordance with all applicable patient confidentiality requirements to support decisions about care coordination involving the County-contracted SUD network providers, County health plan network providers, and DMH specialty mental health network providers. The County-contracted SUD provider network is already

actively engaged in care coordination with mental health and physical health providers through the infrastructure established for the Cal MediConnect project as described above.

DPH-SAPC coordinates with the County Medi-Cal managed care health plans to ensure that beneficiaries have access to and receive SUD services through health plan network providers for services reimbursable by Medi-Cal but not included in the DMC-ODS benefits such as voluntary inpatient detoxification services in general acute hospitals (ASAM Levels 3.7-WM, 4-WM) and Screening, Brief Intervention and Referral to Treatment (SBIRT) services (ASAM Level 0.5) in primary care settings.

DPH-SAPC also has a well-established care coordination relationship with DHS, which provides physical health services for Medi-Cal beneficiaries under an agreement with L.A. Care, and also for the uninsured safety net population.

The expansion of SUD services available under the DMC-ODS implementation plan greatly improves access to SUD services for persons with co-occurring mental health and physical health conditions, particularly in terms of access to residential treatment services, which have historically been difficult to access for medically indigent individuals due to limited County, State and federal funding.

7. COORDINATION ASSISTANCE

The following coordination elements are listed in the STCs. Based on discussions with your health plan and providers, do you anticipate substantial challenges and/or need for technical assistance with any of the following? If so, please indicate which and briefly explain the nature of the challenges you are facing.

- ***Comprehensive substance use, physical, and mental health screening;***
- ***Beneficiary engagement and participation in an integrated care program as needed;***
- ***Shared development of care plans by the beneficiary, caregivers and all providers;***
- ***Collaborative treatment planning with managed care;***
- ***Care coordination and effective communication among providers;***
- ***Navigation support for patients and caregivers; and***
- ***Facilitation and tracking of referrals between systems.***

The following challenges have been identified for effective provision of coordinated and integrated mental health, physical health, and SUD services for beneficiaries with multiple, co-occurring conditions:

- Patient Data-Sharing Between Systems – The current requirements of 42 Code of Federal Regulations (CFR) Part 2 make sharing of patient information between systems cumbersome. State advocacy to revise or waive these requirements for the Waiver demonstration would allow more effective and efficient care coordination practices.

  DPH-SAPC is presently an active participant in County efforts to establish an electronic health records system that would allow patient data exchange between physical health,

mental health, and SUD service systems. DPH-SAPC is also engaged with DMH, DHS, and County health plans to establish a patient consent form that would be used by all partners to authorize exchange of patient information for the purposes of care coordination.

- Payment Reform – Current Medi-Cal payment systems for mental health, physical health, and SUD services are cumbersome, and discourage effective and efficient coordinated or integrated care approaches. The changes to permit same-day billing for Medi-Cal reimbursed services (physical, mental health, SUD) for counties participating in the waiver, as outlined in the DHCS' Information Notice 16-007, is a significant step to improving and supporting cross-system coordinated and integrated care and should be maintained. Payment and provider enrollment incentives for Medi-Cal providers with coordinated and integrated care approaches to service delivery would further promote the adoption of such approaches as the standard for statewide service delivery.

  DPH-SAPC is actively engaged with the County lobbyist, the advocacy efforts of provider associations and the County Behavioral Health Directors Association of California, and DHCS to enact federal, State, and County legislation and regulatory changes needed to advance coordinated and integrated care by removing barriers described above.

- Cross-System Workforce Development – The workforces in mental health, physical health and SUD service networks have limited expertise in identifying and addressing multiple co-occurring conditions through care coordination, with a cross-systems, integrated approach. Workforce training on best practices for patient screening, problem and risk identification, brief intervention for substance use problems, and patient engagement in SUD services are needed for the mental health and physical health workforces. Training in care coordination is needed by all three workforces.

  DPH-SAPC is actively engaged with DHS and DMH along with the County-designated Medi-Cal managed care health plans, and other stakeholder groups to implement cross-system workforce training on effectively working with persons with SUD among other multiple co-occurring conditions.

8. ACCESS

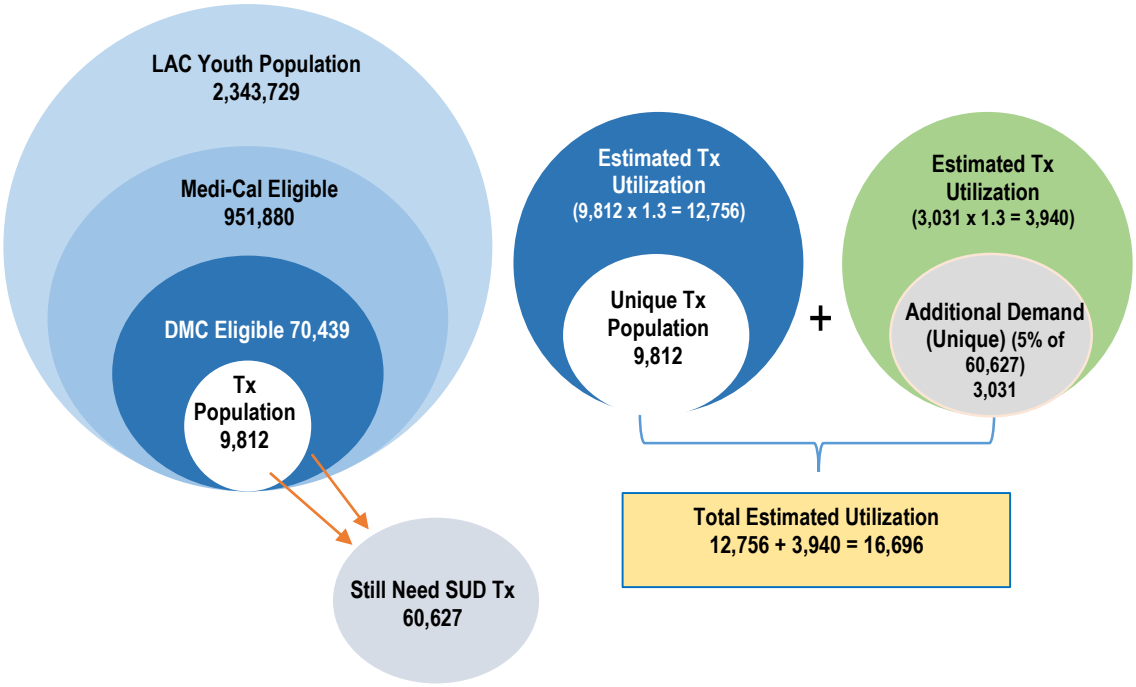
Describe how the county will ensure access to all service modalities. Describe the county's efforts to ensure network adequacy. Describe how the county will establish and maintain the network by addressing the following:

- ***The anticipated number of Medi-Cal clients;***
- ***The expected utilization of services;***
- ***The numbers and types of providers required to furnish the contracted Medi-Cal services;***
- ***Hours of operation of providers;***
- ***Language capability for the county threshold languages;***
- ***Timeliness of first face-to-face visit, timeliness of services for urgent conditions, and access to afterhours care; and***
- ***The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities.***

DPH-SAPC conducted an analysis to project utilization of SUD services given the expansion of Medi-Cal eligibles and LOCs reimbursable under DMC. Based on analysis of 2013 census data, approximately 2.8 million people are estimated to be at or below 138 percent of the federal poverty limit (FPL) and potentially eligible for Medi-Cal in Los Angeles County. Of those 2.8 million people, about 951,880 are estimated to be youth and 1.8 million are estimated to be adults. According to the National Survey on Drug Use and Health (NSDUH) data, the estimated prevalence of SUDs among adults in poverty is about 13 percent, and about 7.4 percent in youth. Using these prevalence rates, DPH-SAPC estimates that approximately 70,439 youth and 236,338 adults are DMC eligible, and thus may need DMC services, in Los Angeles County.

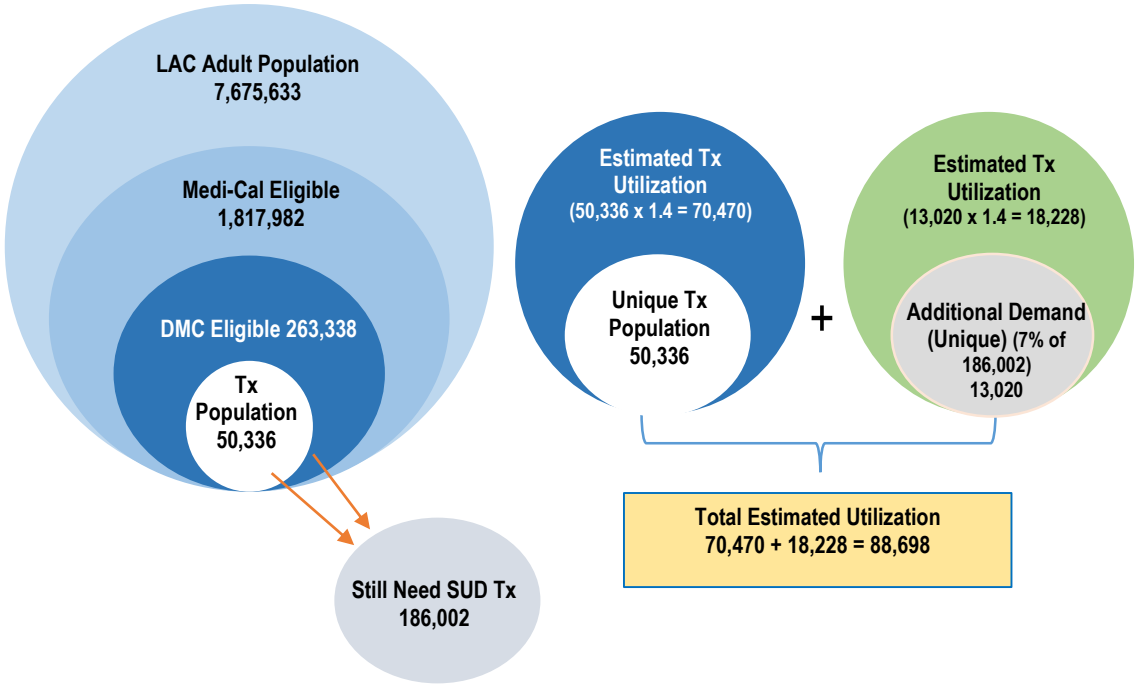
Averaging historical youth (12-17) utilization data over the last 10 years, the annual unique patients served amounted to 9,812 with an average of 1.1 readmissions per patient. DPH-SAPC's projected utilization assumed either stable (low –1.1) or increased (medium – 1.3; high – 1.6) readmissions per patient to the same or different LOC given increased access to appropriate care and improved care coordination. Utilizing these readmission variables to estimate total utilization and applying them to the aforementioned DMC eligible estimates, the estimated range of annual youth patients served is 10,793 (low readmission estimate) to 20,549 (high readmission estimate). This range of utilization numbers provides an estimate of anticipated volume for early phases of the DMC-ODS waiver, in addition to anticipated volume in late phases of the DMC-ODS waiver, assuming enhanced access to SUD services and flow between LOCs. Using medium-level estimates (readmission variable 1.3), Los Angeles County anticipates total utilization of at least 16,696 duplicated youth served annually of which 63 percent (10,518) are expected to need outpatient, 27 percent (4,508) intensive outpatient, and 10 percent (1,670) residential; another 60,627 youth are expected to need but not seek SUD services (Figure 4).

Figure 4: DMC-ODS Medium Utilization Estimation for Youth



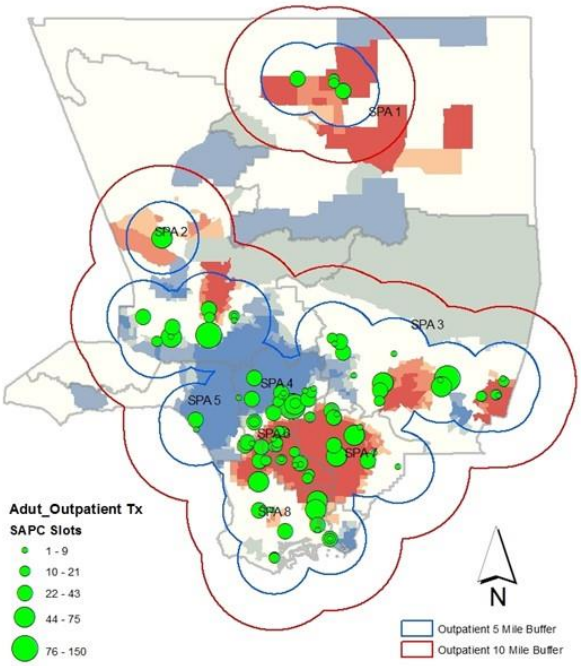
Averaging historical adult utilization data over the last 10 years, the annual unique patients served amounted to 50,336 with an average of 1.2 readmissions per patient. DPH-SAPC's projected utilization assumed either stable (low –1.2) or increased (medium – 1.4; high – 1.8) readmissions per patient to the same or different LOC given increased access to appropriate care and improved care coordination. Utilizing these readmission multipliers to estimate total utilization and applying them to the aforementioned DMC eligible estimates, the estimated range of annual patients served is 60,403 (low readmission estimate) to 114,041 (high readmission estimate). This range of utilization numbers provides an estimate of anticipated volume for early phases of the DMC-ODS waiver, in addition to anticipated volume in late phases of the DMC-ODS waiver, assuming enhanced access to SUD services and flow between LOCs. Using medium-level estimates (readmission multiplier 1.4), Los Angeles County anticipates total utilization of at least 88,698 duplicated adults served annually, with another 186,002 adults in need of SUD services (Figure 5). It is expected, however, that utilization may increase for both youth and adults as services become more accessible County-wide, individuals become aware of the SUD benefits, care coordination and case-management improves, and stigma declines.

Figure 5: DMC-ODS Medium Utilization Estimation for Adults



Using the medium utilization estimates described above and the provider survey on bed and slot capacity conducted by DPH-SAPC last year, there is a potential deficit in adult outpatient, intensive outpatient, residential, withdrawal management and opioid treatment programs services depending on how quickly new services are accessed and how quickly capacity is expanded (Figures 6, 7, 8, 9, 10). DPH-SAPC plans to conduct a similar analysis for youth utilization estimates (expected completion date June 2016) and will use both adult and youth utilization estimation analyses and other analyses (e.g., primary language hot spot analysis) to determine service gaps/needs. These data will inform a solicitation process to further improve access to care for beneficiaries by year two of the pilot, with continued expansion in year three as needed.

Figure 6: Adult Outpatient – Medium Utilization Estimate

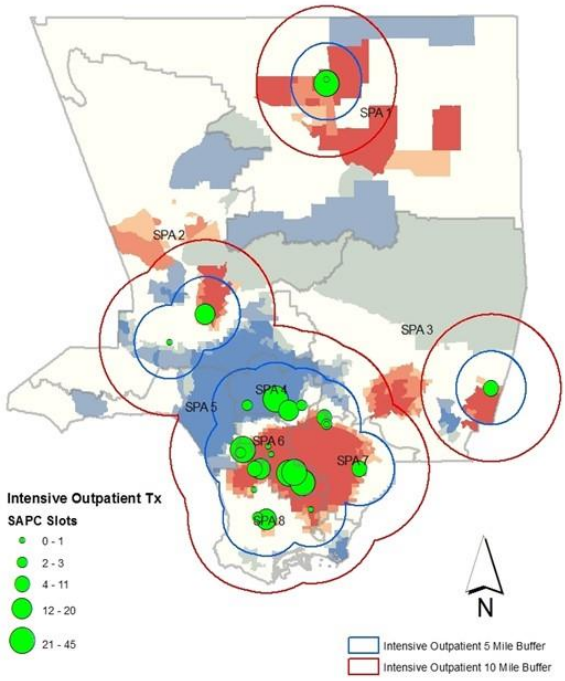


Red areas indicate the highest concentration of DMC eligible people;
Blue areas indicate the lowest concentration of DMC eligible people.

Slot Utilization and Capacity	Number
Total estimated utilization	88,698
Current utilization	30,557
Estimated utilization	36,366 (41%)
Patients per slot per year	7*
Total slots needed	5,195
SAPC slot capacity	2,402
Additional slots needed	2,793
Number of Facilities	98

* Patients per slot per year was estimated based on the current LOS utilization pattern: Length of stay of 60days (60%), 90 days (15%), 120 days (25%); Days of services per week (up to 9 hours)—5 days (30%), 3 days (50%), 1 day (20%); roughly came out 7 clients per slot per year (7.2)

Figure 7: Adult Intensive Outpatient – Medium Utilization Estimate

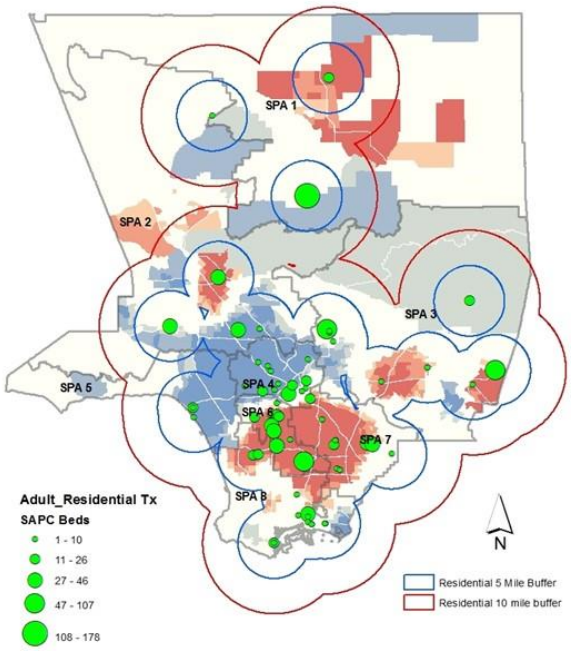


Red areas indicate the highest concentration of DMC eligible people;
Blue areas indicate the lowest concentration of DMC eligible people.

Slot Utilization and Capacity	Number
Total estimated utilization	88,698
Current utilization	2,102
Estimated utilization	5,322 (6%)
Patients per slot per year	5*
Total slots needed	1,064
SAPC slot capacity	375
Additional slots needed	689
Number of Facilities	26

*Patients per slot per year was estimated based on the current LOS utilization pattern: Length of stay--60days (55%), 100 days (20%), 130 days (25%); Days of services per week (up to 9-19 hours), 5 days (50%) 3 days (50%); roughly came out 5 clients per slot per year (5.3).

Figure 8: Adult Residential – Medium Utilization Estimate

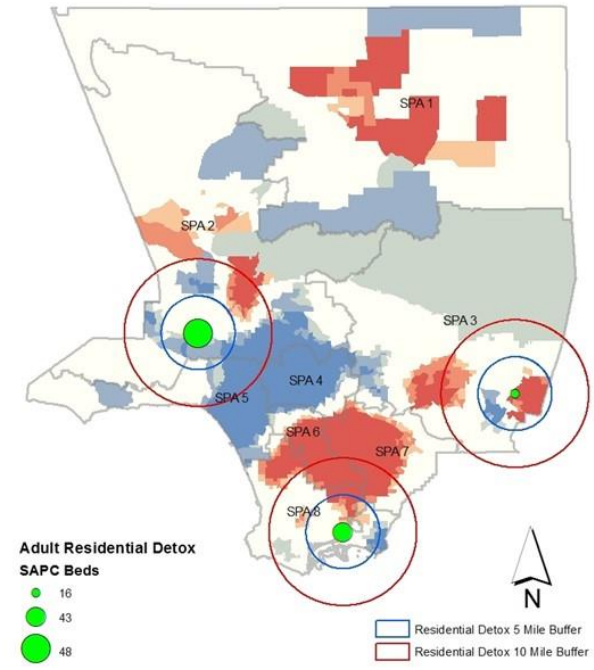


Red areas indicate the highest concentration of DMC eligible people;
Blue areas indicate the lowest concentration of DMC eligible people.

Bed Utilization and Capacity	Number
Total estimated utilization	88,698
Current utilization	10,245
Estimated utilization	14,192 (16%)
Patients per bed per year	6*
Total beds needed	2,365
SAPC bed capacity	1,220
Additional Beds needed	1,145
Unfunded beds	697
Additional beds needed after using unfunded beds	448
Number of Facilities	75

*Patients per bed per year was estimated based on the current length of stay utilization pattern: 30days (30%), 60 days (40%), 90 days (20%), 120 days (10%) that concluded roughly 6 clients per slot per year (5.8).

Figure 9: Adult Residential Medical Detox – Medium Utilization Estimate

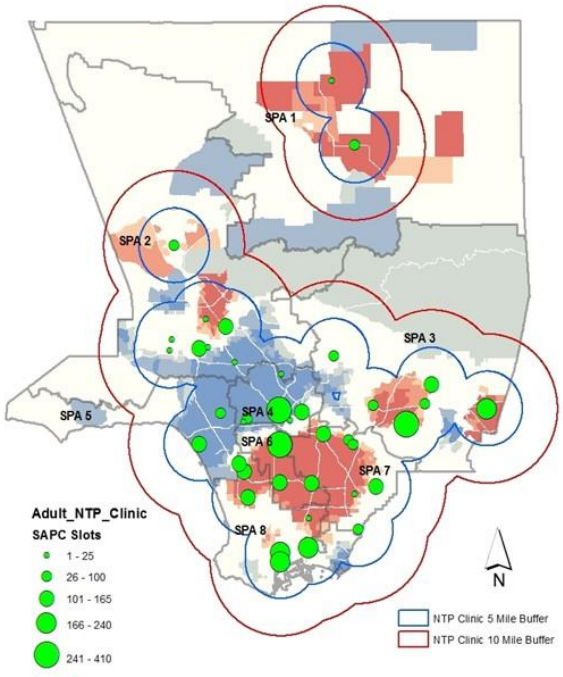


Red areas indicate the highest concentration of DMC eligible people;
Blue areas indicate the lowest concentration of DMC eligible people.

Bed Utilization and Capacity	Number
Total estimated utilization	88,698
Current utilization	4,200
Estimated utilization	6,209 (7%)
Patients per bed per year	40*
Total beds needed	155
SAPC bed capacity	107
Additional beds needed	48
Unfunded beds	0
Additional beds needed after using unfunded beds	48
Number of Facilities	3

*Patients per bed per year was estimated based on the current length of stay utilization pattern: 7 days (70%), 14 days (30%); that concluded roughly 40 clients per slot per year.

Figure 10: Adult Opioid Treatment Program – Medium Utilization Estimate



Red areas indicate the highest concentration of DMC eligible people;
Blue areas indicate the lowest concentration of DMC eligible people.

Slot Utilization and Capacity	Number
Total estimated utilization	88,698
Current utilization	13,299
Estimated utilization	21,288 (24%)
Patients per slot per year	3*
Total slots needed	7,096
SAPC slot capacity	5,373
Additional slots needed	1,723
Number of Facilities	39

*Patients per slot per year was estimated based on the current length of stay utilization pattern: 90 days (30%), 120 days (20%), 150 days (30%), 180 days (20%) that concluded roughly 3 clients per slot per year.

DPH-SAPC currently contracts with community-based organizations to provide all LOCs and directly operates one residential facility and outpatient program (AVRC) for adults. Facilities may serve youths only, adults only, or youth and adults. Currently, approximately 52 percent of outpatient, 55 percent of intensive outpatient, one percent of residential, 88 percent of opioid treatment program, and zero percent of withdrawal management sites are currently DMC certified. DPH-SAPC is actively working with contractors who provide residential services to obtain DMC certification/licensure as soon as possible, and all contracted agencies and sites will be required to obtain the appropriate DMC certification/licensure by July 1, 2017. DPH-SAPC is able to provide each LOC described in the benefit package within the County, but expansion will be needed to ensure adequate access and availability by age population, especially for youth (Table 4, Attachment 3). Efforts will be made by the County to include other appropriate treatment service agencies countywide that can fill level of care gaps for youth; thereby, eliminating the need to refer a youth to neighboring counties.

Table 4: Number of Contracts and Sites by Population Served

Level of Care	DMC Certified		Non-DMC Certified		Total # Agencies (N=93)	Total # Sites (N=383)
	# of Agencies	# of Sites	# of Agencies	# of Sites		
Youth Serving Only						
Outpatient	0	0	7	7	7	7
Intensive Outpatient*	0	0	0	0	0	0
Residential	0	0	1	1	1	1
Youth and Adult Serving						
Outpatient	6	10	2	2	8	12
Intensive Outpatient	0	0	0	0	0	0
Residential	1	1	2	3	3	4
Adult Serving Only						
Outpatient – General	44	85	26	84	61	169
Outpatient – Perinatal	14	21	7	13	20	34
Intensive Outpatient – General	22	31	12	28	30	59
Intensive Outpatient – Perinatal	12	15	6	9	16	24
Residential – General	0	0	39	94	39	94
Residential – Perinatal	0	0	7	14	7	14
Residential – Detox	0	0	3	4	3	4
Opioid Treatment – General	16	39	2	6	17	45
Opioid Treatment – Perinatal	1	4	0	0	1	4
Recovery Residence-Perinatal	0	0	9	53	9	53
Recovery Residence	0	0	9	14	9	14
* The report used to generate this table is based on contract type, therefore, it is likely that youth contractors provide non-DMC certified intensive outpatient services but it was not captured based on available data.						

According to DHCS information, state-licensed residential treatment and residential detoxification programs have a total of 5,895 beds available in Los Angeles County, including those already contracted by the DPH-SAPC. A total of 277 state-certified non-residential treatment programs operate in the County, including those already contracted by the DPH-SAPC. Therefore, there exists a large inventory of outpatient services and residential beds that presently are not contracted by the County. While some of this capacity is likely committed to other purchasers of services, such as the State correctional system and commercial health insurance plans, it is likely that a substantial inventory remains unfunded and demonstrates potential for DMC certification to support expanded service needs as DMC-ODS is implemented.

Efforts are underway to better define requirements for site-specific certification and to increase the number of SUD network providers with the DMC certification. The greatest concern for the County, however, is the timeliness with which the State is able to process new DMC applications, particularly for residential services. Until DPH-SAPC's network providers of residential services are DMC-certified, these benefits must be funded under other capped funding sources, which limit the number of available treatment beds, causing patients to be served in

LOCs below what is determined to be medically necessary. As a result, both the County and State may be at risk for liability by not providing adequate medically determined LOCs.

Additional Accessibility Factors

While increasing the availability of services in underserved parts of the County is essential to increasing rates of SUD treatment and improving health outcomes, so is meeting the needs of beneficiaries in terms of flexible hours of operation, services in their preferred language, the ability to receive services when needed, and easily accessible locations (non-clinic based, proximity to home/work). DPH-SAPC will encourage and assist SUD network providers to continually take steps to provide services that meet beneficiaries' needs and preferences, but at minimum this includes the following standards:

- Hours of Operation: All outpatient and intensive outpatient services will operate at least five days a week (including one weekend day), and at least two days will include evening hours (5:00 PM to 9:00 PM, at a minimum). Residential programs will operate 24 hours per day, seven days a week, and will accept intakes at least during regular weekday business hours (9:00 AM to 5:00 PM). Assuming financial feasibility in terms of the ability to support necessary workforce and infrastructure investments, DPH-SAPC will work with its network of providers to expand hours of operation in both outpatient and residential settings, with particular focus on expanding access to intake appointments on the weekend by July 2018.

- Language Capability: Currently about 71 percent of DPH-SAPC contracted sites offer bilingual services and 68 percent of them are in Spanish, according to the provider survey. Services will be provided in all threshold languages as needed. Services in Spanish will be offered by all network providers. Services in other languages may be offered by specific programs that serve specific cultural populations. The County also maintains a contract with Interpretation Services that provides oral interpretation services in at least the 12 threshold languages (other than English) as indicated by the Medi-Cal Eligibility Data System (MEDS) that is accessible to all of its network providers. These languages are: Arabic, Armenian, Cantonese, Farsi, Khmer (Cambodian), Korean, Mandarin, Russian, Spanish, Tagalog, Vietnamese and other Chinese. DPH-SAPC recognizes the importance of ensuring the availability and accessibility of services that can effectively serve individuals with diverse backgrounds and needs, and therefore will fully comply with State requirements regarding delivery of services in compliance with 42 CFR 438.206(c)(2).

- Timeliness of Services:

  First face-to-face visit – The Beneficiary Access Line will set the appointment for the initial assessment/intake with the selected provider while the beneficiary is on the call except under limited circumstances (e.g., the caller is unable to schedule, the automated appointment system is not yet developed/not working), but no longer than three business days from the brief triage assessment. Unless the beneficiary has specific provider or other preferences (e.g., cultural/linguistic specific services), the assessment/intake with a qualified SUD

network provider that is geographically accessible will be conducted within 15 business days from the initial brief triage assessment; beginning in July 2017 the assessment/intake target will be five business days for outpatient and 10 business days for residential LOCs and five business days for all LOCs by July 2018.

For individuals that present at the provider site first, the same timeliness expectations apply and alternate referrals should be offered and documented if this cannot be achieved before placing the individual on a waitlist. Waitlists will be tracked with the automated appointment system that is expected to be ready by July 2017. Expedited or other suitable/appropriate accommodations for scheduling appointments will be made for urgent situations whenever possible. DPH-SAPC will regularly evaluate timely receipt of services, including seeking service expansion to improve the ability to receive services upon demand.

Emergencies – For emergency situations when an individual presents either in-person or on the phone with life-threatening condition, the Beneficiary Access Line or network provider will immediately contact emergency medical services for intervention. Network providers will be required to establish procedures for appropriately handling urgent conditions presented by actively enrolled beneficiaries.

Afterhours care – Network providers will be required to establish procedures for appropriately handling afterhours care needs of actively enrolled beneficiaries. In addition, the patient may contact the Beneficiary Access Line for a referral to an agency that provides 24 hour care or assistance.

- Geographic Location of Providers: A criterion for making referrals for placement in outpatient services will be that the program should be within 30 minutes travel time by personal or public transportation, or 10 miles to and from the beneficiary's location of choice. In some outlying semi-rural areas of the County such as in the Antelope Valley, the low population density may make this criterion impossible to meet, particularly through public transportation. In such cases, every effort will be made to accommodate the beneficiary to minimize excessive travel time.

  Telehealth approaches will also be considered after the initial 12-month implementation period as a means to expand access to services for beneficiaries in outlying areas and for those with transportation challenges.

All County-contracted SUD network providers will be fully compliant with the Americans with Disabilities Act requirements as a contract provision.

9. TRAINING PROVIDED

What training will be offered to providers chosen to participate in the Waiver? How often will training be provided? Are there training topics that the county wants to provide but needs assistance?

Review Note: Include the frequency of training and whether it is required or optional.

All network providers will be required to establish and operate an employee training plan for their employees that includes a training needs assessment and describes steps to ensure that employees receive appropriate training aligned with their responsibilities, clinical or otherwise. At minimum, this includes training on the ASAM Criteria, DSM-V, Motivational Interviewing, Cognitive Behavioral Therapy, Culturally and Linguistically Appropriate Services (CLAS), and clinical documentation for all direct service staff at the frequency prescribed by DPH-SAPC. Network providers will be monitored at least annually for compliance with this contract requirement, including ensuring compliance with the minimum number of annual training hours (currently 24 hours per direct service staff) and receipt of booster sessions for the above listed core trainings in accordance with the employee training plan and County requirements.

In addition, DPH-SAPC will be responsible for assessing overall network clinical training needs and coordinating training sessions in alignment with providers' training needs assessment findings. Contracts with the California Institute for Behavioral Health Services and the UCLA-Integrated Substance Abuse Programs serve as the primary vehicles for provision of clinical and program capacity-building training, and technical assistance for its network providers.

Current training topics identified for the DMC-ODS implementation include the following: application of the ASAM Criteria and determination of medical necessity, clinical documentation, and evidence-based practices (Motivational Interviewing, Cognitive Behavioral Therapy, and Medication-Assisted Treatment). Additional trainings topics (e.g., CLAS, data integrity) will also be offered in the future to better ensure a well-trained and capable workforce. The County will use a train-the-trainers approach to build a cadre of highly skilled medical directors and clinical supervisors within the provider network who will then train employees within each provider organization and monitor fidelity to adopted evidence-based practices. To accommodate the diversity and size of the County-contracted SUD provider network and its workforce, training will be continuous throughout the demonstration period and beyond.

10. TECHNICAL ASSISTANCE

What technical assistance will the county need from DHCS?

The County requests technical assistance from the State on the following topics:

- How DMC minor consent restrictions (e.g., parental consent) relate to the ability of minors age 12 and above to consent to treatment per California Family Code 6929, including balancing parental involvement and privacy concerns for minors receiving treatment.
- How to obtain reimbursement for SUD services under Early Periodic Screening, Diagnosis and Treatment (EPSDT), including what service billing codes should be used.

11. QUALITY ASSURANCE

Describe the quality assurance activities the county will conduct. Include the county monitoring process (frequency and scope), Quality Improvement plan, Quality Improvement committee activities and how counties will comply with CFR 438 requirements. Please also list out the members of the Quality Improvement committee. Also, include descriptions of how each of the quality assurance activities will meet the minimum data requirements.

The County established a *Quality Improvement and Utilization Management (QI/UM) Plan* in consultation with its provider network and stakeholders, and in compliance with DMC-ODS requirements (Attachment 4). The broad objective of the QI/UM program is for patients receiving SUD services to receive effective, coordinated care that is the right service provided at the right time, in the right setting, and at the right intensity and duration.

Quality Improvement Program

The purpose of the QI program is twofold: 1) to establish an infrastructure for quality-focused services through the formation of a number of committees that focus on specific aspects of an organized delivery system of SUD services; and 2) to set standards in areas such as medical necessity criteria, clinical practice (including medication-assisted treatment), and LOC guidelines as founded on the ASAM Criteria. The components of these QI standards will also focus on performance and outcome measures, care coordination, workforce standards, risk management, Quality Improvement Projects (QIP) at the provider level, and a grievance and appeals process. SUD measures will monitor key quantitative and qualitative characteristics of the system of care including, but not limited to:

- Timeliness of first face-to-face appointment;
- Timeliness of services for urgent conditions;
- Timeliness of first dose of NTP
- Frequency of follow-up appointments;
- Access to afterhours care;
- Responsiveness of the beneficiary access line;
- Strategies to reduce avoidable hospitalizations;
- Coordination of physical and mental health services at the provider level; and
- Assessment of the beneficiaries' experiences.

The QI program will establish various committees including: Quality Improvement/Risk Management (QI/RM), Utilization Management, Research and Data Management, Professional Development, Community Liaison (with subcommittees for providers and consumers), and Cultural Competence. The QI/RM Committee will meet every other month and consist of DPH-SAPC representatives from each major division/unit, including the Director's Office, Office of the Medical Director and Science Officer, Adult and Youth Programs, Contracts, Strategic Planning, Information Systems, Finance, and the evaluation services contractor who will be collaborating with DPH-SAPC on quality assurance and

training activities. The QI/RM Committee will work closely with all other committees in order to incorporate feedback into the continuous quality improvement process.

The QI program section of the *Quality Improvement and Utilization Management Plan* (Attachment 4) includes further detail on how DPH-SAPC intends to address the following topics: access to care, workforce, documentation, medical necessity criteria, clinical practice guidelines, levels of care guidelines, recovery support services, case-management/care coordination, performance and outcome measures, peer review quality improvement projects, confidentiality risk management, and complaints/grievances and appeals process. This attachment also describes how these activities will meet the minimum data requirements of the DMC-ODS.

Utilization Management Program

The UM program analyzes how the DPH-SAPC provider network is delivering services and how it is utilizing resources for eligible patients. The various responsibilities of the UM program include: ensuring adherence to established eligibility and medical necessity criteria; ensuring that clinical care and ASAM level of care guidelines are followed; conducting clinical case reviews (prospective/ concurrent/retrospective) of requests for select services; authorization of select services; random and retrospective monitoring of a portion of provider caseloads; and ongoing monitoring and analysis of provider network service utilization trends. In summary, the purpose of the UM program is to achieve the following objectives for patients and providers:

- To assure effective and efficient utilization of facilities and services through an ongoing monitoring program designed to identify patterns in under-utilization, over-utilization, and inappropriate utilization of services across the service continuum
- To assure fair and consistent UM decision-making
- To focus resources on a timely resolution of identified problems
- To assist in the promotion and maintenance of optimally achievable quality of care
- To educate health care professionals on appropriate and cost-effective use of health care resources.

Provider caseloads for adolescents and adults at each ASAM LOC will be randomly and retrospectively reviewed on at least an annual basis, in addition to the cases that require authorization and pre-authorization. UM staff may also conduct focused chart reviews whenever concerns arise about a particular provider or patient. Such reviews may be conducted onsite and without prior notice to the provider. Reportable incidents are patient safety events that result in death, permanent harm, and/or severe temporary harm, and intervention required to sustain life. Reportable incidents must be investigated by the provider's Risk Management Committee, and must be reported to the SAPC QI/RM Committee immediately.

The UM Program section of the *Quality Improvement and Utilization Management Plan* (Attachment 4) includes further detail on how DPH-SAPC intends to address the following topics: eligibility and medical necessity review process and clinical case review process.

Compliance with CFR 438

The QI/UM plan is in compliance with CFR 438.200, 438.202, and 438.204. The QI/RM Committee that is built into the QI program will conduct periodic reviews to ensure ongoing compliance. DPH-SAPC will ensure compliance with CFR 438 Subpart E by appropriately addressing any quality related concerns identified by the DHCS contracted External Quality Review Organization that will conduct annual reviews of the SUD services provided within this system of care. DPH-SAPC will also conduct the various monitoring processes described above, and comply with data reporting requirements.

12. EVIDENCE-BASED PRACTICES

How will the counties ensure that providers are implementing at least two of the identified evidence-based practices? What action will the county take if the provider is found to be in non-compliance?

The County will require that its network providers implement and use, at minimum, the evidence-based practices (EBPs) of Cognitive Behavioral Therapy and Motivational Interviewing by July 2016. In addition, network providers will be encouraged to adopt additional evidence-based practices and promising practices tailored to the needs of each provider's focus patient population. Implementation of these EBPs will be a contract requirement and monitored through the contract compliance monitoring process. In accordance with current contract language and monitoring guidelines, Contract Services Division will oversee and conduct at minimum annual site visits to ensure EBP's are being conducted effectively and with fidelity. Any non-compliance issues with be addressed with appropriate provider staff and resolved through a corrective action plan, up to and including contract termination. Corrective action ranging from technical assistance to disallowance will occur depending on the nature of the deficiency, frequency and/or severity of the findings.

13. ASSESSMENT

Describe how and where counties will assess beneficiaries for medical necessity and ASAM Criteria placement. How will counties ensure beneficiaries receive the correct level of placement?

Beneficiaries will be first engaged in a brief triage assessment by the Beneficiary Access Line or at the SUD provider site to establish the provisional LOC recommendation. The beneficiary will then be assessed by the contracted SUD treatment provider for medical necessity and appropriate LOC based on the ASAM Criteria. SUD treatment providers will be required to have LPHAs determine medical necessity, Clinical staff (e.g., registered interns, certified counselors, LPHAs) will be trained on and required to use the ASAM Criteria for placement decisions, continued service, and transfer/discharge. The County will encourage all providers to use the ASAM Continuum Software (ASAM-CS), which at the present time only pertains to the adult

population, although paper-based assessment based on the ASAM Criteria will also be allowable if the tool is pre-approved by the County.

Contract monitoring and the UM program will provide a multi-layered approach to ensuring that beneficiaries are placed at the appropriate LOC. Providers will be required to maintain a record of ASAM assessments. Case reviews conducted as part of UM activities will ensure appropriate LOC placement at the initial assessment, and for purposes of continued service and transfer/discharge.

14.REGIONAL MODEL

If the county is implementing a regional model, describe the components of the model. Include service modalities, participating counties, and identify any barriers and solutions for beneficiaries. How will the county ensure access to services in a regional model (refer to question 7)?

Los Angeles County will not be implementing a regional model.

15.MEMORANDUM OF UNDERSTANDING

Submit a signed copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery as described in 4(i) of the STCs. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s).

MOUs between the DPH-SAPC, the two Medi-Cal managed care plans (Health Net and LA Care), and DMH are in the process of execution and will be submitted within 90 days of the approval of the County implementation plan as required. The MOU will include all conditions as required by the State (Attachment 2). DPH-SAPC has already executed MOUs describing care coordination policies and procedures with the health plans and DMH for the Cal MediConnect program.

16.TELEHEALTH SERVICES

If a county chooses to utilize telehealth services, how will telehealth services be structured for providers and how will the county ensure confidentiality? (Please note: group counseling services cannot be conducted through telehealth).

Some County-operated and contracted SUD providers currently offer telehealth services, including telepsychiatry. DPH-SAPC will encourage all SUD providers to expand or introduce telehealth as an offered service, and will explore telehealth as a means to expand the availability of medication-assisted treatments, physician consultations, and services for special populations, among other services. DPH-SAPC will also explore increased collaboration with DMH and Medi-Cal managed care plans in an effort to expand these services. All telehealth services

offered at County-contracted SUD providers will be required to use special equipment and/or software that meets telehealth encryption standards and that can ensure confidentiality. The telehealth equipment will be set up in a private room that is locked and secure.

17. CONTRACTING

Describe the county's selective provider contracting process. What length of time is the contract term? Describe the local appeal process for providers that do not receive a contract. If current DMC providers do not receive a DMC-ODS contract, how will the county ensure beneficiaries will continue receiving treatment services?

Review Note: A list of all contracted providers (modality, provider, address) must be submitted to DHCS within 30 days of the waiver implementation date and as new providers are awarded contracts. DHCS will provide the format for the listing of providers.

The County establishes master agreements with qualified community-based SUD service providers through a selective contracting process. Once master agreements are executed with providers that meet County requirements, contracts are established with these legal entities who demonstrate capabilities and capacities to provide one or more of the ASAM LOCs included in Los Angeles County's benefit package for youth and/or adults. Using this approach, the County ensures that its network providers each possess the business, clinical, and specific patient populations capacities and competencies to effectively provide the contracted services; and that the service network has the optimal capacity of service providers to meet the needs of the County population. A listing of all contracted providers including information on service modality and provider address is attached as required (see Attachment 3).

Contract Term

All contracts will have a term of three years, with the option to extend on an annual basis. SAPC will utilize current contracts to initiate participation in the waiver while developing a new Request for Service Qualifications and associated Work Order Solicitations to expand the number of DMC certified LOCs throughout the County and to more thoroughly incorporate the new contract expectations that come with this system transformation. The new contracts are anticipated to have a five year term with up to five one-year extensions based on provider performance and need. All SUD network providers will be required to be DMC-certified for contracted LOCs by July 2017.

Appeals Process

Under Board Policy No. 5.055 (Services Contract Solicitation Protest), any prospective contractor may request a review of the requirements under a solicitation for a Board-approved services agreement. Additionally, any actual contractor may request a review of a disqualification under such a solicitation. The appeal process will follow the Los Angeles County Protest Policy (available at: http://mylacounty.info/listserver/pcs_contracts/cms1_19157.pdf).

Continuity of Services

Any current SUD provider not awarded a contract, or who is terminated as a contractor, will be notified at least 30 days prior to contract termination. Provider experience, quality, and history in terms of the provision of care, fraud, waste, and abuse will be components of the decision-making process when awarding or terminating contracts. In accordance with existing contract language, such providers shall make immediate and appropriate plans to transfer or refer all current patients to SUD network providers for continuing service in accordance with the patient's needs. Such plans shall be approved by DPH-SAPC before any transfer or referral is completed except in those instances, as determined by SUD provider, where an immediate patient transfer or referral is indicated. In such instances, the SUD provider may make an immediate transfer or referral to the nearest SUD network provider.

18.ADDITIONAL MEDICATION-ASSISTED TREATMENT

If the county chooses to implement additional MAT beyond the requirement for NTP services, describe the MAT and delivery system.

In addition to medications used by Opioid Treatment Programs (methadone), the County will offer to its beneficiaries all addiction medications approved by the Food and Drug Administration as determined medically necessary. These medication-assisted treatments (MAT) include acamprosate, buprenorphine, disulfiram, naloxone, and naltrexone (oral and extended release formulations). Addiction medications are prescribed and administered by qualified SUD network providers or through coordination with the beneficiaries' Medi-Cal managed care health plan network pharmacy and primary care providers. Currently, within the SAPC network of providers access to MAT occurs via a "hub and spoke" model in which providers with patients who may benefit from MAT refer those patients to one of three MAT "hubs" capable of prescribing MAT. Throughout the demonstration period, DPH-SAPC will explore opportunities to expand access to MAT, either through the expansion of the current MAT hub network, utilizing telehealth, or by facilitating regional networks of providers who collectively fund and share a local MAT prescriber. The MAT hub network currently consists of three "hubs" with the infrastructure and staffing to provide MAT, including methadone, buprenorphine, naltrexone, and other MAT. MAT hubs accept both internal referrals from within their agency, as well as external referrals from other SUD providers who have identified a beneficiary who is interested and appropriate for MAT. These MAT hubs expand access and availability of MAT to a diverse pool of SUD providers as the County continues to work to expand MAT by increasing the number of MAT hubs and MAT prescribers both within the SUD system of care, and within the physical and mental health systems.

19.RESIDENTIAL AUTHORIZATION

Describe the county's authorization process for residential services. Prior authorization requests for residential services must be addressed within 24 hours.

Initial Authorization: The County has establish written policies and procedures describing required prior authorization for initial admission to residential services within 24 hours of a network provider's prior authorization request submission in compliance with DHCS

requirements. If relapse risk is deemed to be significant without immediate placement in residential care, a residential treatment provider may admit an individual prior to receiving residential authorization, with the understanding that authorization denials will result in financial loss whereas authorization approvals will be retroactively reimbursed to the date of admission. An automated tracking system will compile the number, disposition, percentage, and timeliness of requests for pre-authorization.

Continuing Authorization: The County will establish written policies and procedures for processing requests for continuing authorization of residential services. Residential services for all adult populations will require reauthorization after 60-calendar days to assess for appropriate LOC utilization. If a one-time extension is warranted, youth residential services will require reauthorization after 30-calendar days to assess for appropriate LOC utilization. Requests for continuation of residential services must be submitted at least seven calendar days in advance of the end date of current authorization for both adult and youth populations. There will be a maximum residential treatment limit of 90-days for adults and 30-days for adolescents, unless medical necessity warrants a one-time extension of up to 30-days on an annual basis. For adult populations, only two non-continuous 90-day regimens will be authorized in a one-year period. For perinatal and criminal justice populations, a longer length of stay of up to six months on an annual basis may be approved based on medical necessity, but only three months with a one-time 30-day extension of the total episode can be funded under DMC.

Residential patients must receive regular assessments of their progress within these 60- and 30-calendar day residential authorizations for adult and youth populations, respectively. Given the fluid nature of clinical progression, the expectation will be that clinical progress note assessments are performed on a regular basis during residential treatment as clinically warranted and that certain patients will not require the full period of authorized residential services. In these instances, patients must be transitioned to a lower level of care as soon as clinically indicated. Required treatment plan updates every 30-days will help to facilitate these regular case reviews to ensure that patients receive care in the least restrictive setting that is clinically appropriate.

If upon clinical review, either during a focused or random retrospective review, an ongoing residential treatment case is determined to be unnecessary based on the aforementioned considerations, UM Unit will have the authority to terminate/modify the current authorization and to deny ongoing reimbursement for residential services, and require transition to an appropriate lower LOC. In these instances, reimbursement for residential services that have already been provided will be maintained, but future reimbursement for the identified episode will be denied. Providers will be responsible for ensuring successful care coordination during all level of care transitions. Providers will be required to notify UM staff of residential discharges and to submit a completed discharge summary within 24 hours.

20.ONE YEAR PROVISIONAL PERIOD

For counties unable to meet all the mandatory requirements upon implementation, describe the strategy for coming into full compliance with the required provisions in the DMC-ODS. Include in the description the phase-in plan by service or DMC-ODS requirement that the county cannot begin upon implementation of their Pilot. Also include a timeline with deliverables.

Review Note: This question only applies to counties participating in the one-year provisional program and only needs to be completed by these counties.

Not applicable for Los Angeles County, as all mandatory requirements are met upon implementation.

County Authorization

Authorization of County Alcohol and Other Drug Program Director:

	Los Angeles	
Wayne K. Sugita, Interim Director Substance Abuse Prevention and Control Department of Public Health	County	Date

Los Angeles County, Department of Public Health
Substance Abuse Prevention and Control

QUALITY IMPROVEMENT / UTILIZATION MANAGEMENT PROGRAM PLAN

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Substance Abuse Prevention and Control (SAPC) is a division of the Department of Public Health, and is responsible for leading and facilitating the delivery of a full spectrum of prevention, treatment, recovery support services for substance use disorders (SUD) across Los Angeles County.

Key organizational objectives are to develop a comprehensive, coordinated, and integrated continuum of care for the treatment of SUD that is accessible, evidence-based, effective, and sustainable. The Quality Improvement / Utilization Management (QI/UM) program plan describes the goals, scope, structure and operations of the SAPC QI/UM program, and pertains to all providers who have contracts with SAPC to provide SUD services in Los Angeles County.

The broad objective of the QI/UM program is for patients receiving SUD services to receive effective, coordinated care that is the right service provided at the right time, in the right setting, and at the right intensity and duration. Guiding principles include:

- Supporting providers to help patients achieve recovery, stability, and functional improvement.
- Ensuring timely access to high quality, evidence-based, medically necessary SUD services in the most appropriate setting.
- Ensuring effective and efficient utilization of SUD services and resources.
- Facilitating and coordinating care between physical health, mental health, and SUD services.
- Ensuring the provision of services that are age-specific and developmentally, culturally, and linguistically appropriate.
- Involving patient support systems (e.g., family members, significant others), when clinically appropriate.
- Assessing, monitoring, and analyzing clinical performance and outcome measures to identify and promote opportunities to improve service delivery, patient outcomes, and overall organizational and provider performance.

Establishing a committee structure within the SAPC will address the needs of the QI/UM program and better coordinate activities in order to meet organizational objectives. These committees include:

- Quality Improvement / Risk Management Committee
- Utilization Management Committee
- Research and Data Management Committee
- Professional Development Committee
- Community Liaison Committee
    - Adult Provider Sub-Committee
    - Youth Provider Sub-Committee
    - Consumer/Family Member Committee
- Cultural Competence Committee

The remainder of this document includes brief overviews of both the QI and the UM programs. This executive summary does not include the same detail as the QI/UM program plan. If questions or concerns arise after reading this summary, please refer to the full QI/UM plan for additional details. If the full plan does not address the question/concern, please contact the SAPC.

QUALITY IMPROVEMENT PROGRAM

The purpose of the Quality Improvement (QI) program is to ensure that the provision of SUD services aligns with the SAPC's organizational mission and goals. Further the QI program will ensure that services follow a standard of clinical practice consistent with medical necessity, best practice, and level of care guidelines described by the American Society of Addiction Medicine (ASAM).

The QI program will implement two models in order to achieve these objectives:

1) *Continuous Quality Improvement (CQI) Model:* The CQI model is a respected quality improvement model that employs a patient-centered philosophy and a long-term approach to quantify what a system should do.

2) *Chronic Care Model (CCM):* The CCM identifies the essential elements of a health care system that encourage high-quality care. Elements include the community, health system, self-management support, delivery system design, decision support and clinical information systems.

Access to Care: One of the central goals of SAPC is to ensure that access to SUD services in Los Angeles County is timely (a Beneficiary Access Line will be established to facilitate more expedient and easier access to services), broad (Los Angeles County provides the majority of the levels of care noted in the ASAM Criteria), and evidence-based (providers will be expected to use a minimum of two evidence-based practices).

Workforce: As a result of the expansion of Medi-Cal, the SUD treatment population is expected to increase significantly. To address the workforce needs of this expanded population, Los Angeles County will work with provider agencies to provide trainings to enhance the quality and capabilities of the current workforce, while also exploring opportunities to expand their number. A diverse workforce in terms of discipline and cultural background will be crucial in order to address the varied needs of the SUD treatment population. Ensuring reasonable caseloads, continuing education, and career ladders as means for professional growth will also be critical in ensuring quality, individualized care, and workforce retention.

Documentation: Increased focus on quality and a biopsychosocial model of care in the SUD field requires that health records (paper-based or electronic) be credible and complete. Los Angeles County requires that SUD treatment providers create initial documentation based on the ASAM Criteria. In addition, progress notes must follow one of four formats: SOAP, GIRP, SIRP, or BIRP. The SOAP (Subjective, Objective, Assessment and Plan), GIRP (Goals, Intervention, Response and Plan), SIRP (Situation, Intervention, Response and Progress), and the BIRP (Behavior, Intervention, Response and Plan) are specific methods of documentation that describe the format and content of progress notes to ensure communication and monitoring of patient interactions. The full QI/UM plan provides additional details concerning the characteristics of each type of note (e.g., progress notes, treatment plans, assessment information, summary of progress, etc.)

Clinical Practice Guidelines and Evidence Based Practices (EBP): The QI program also includes descriptions of the medical necessity criteria (patients must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders [DSM] for a SUD and meet the ASAM criteria definition), clinical practice guidelines, the appropriate utilization of medication-assisted treatments (MAT) and evidence based practices or EBPs (e.g., motivational interviewing, cognitive behavioral therapy, relapse

prevention, trauma informed treatment, psychoeducation). SUD providers are at a minimum expected to implement the two EBPs of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT).

Cultural Competency: Research indicates that lack of cultural competency in the design and delivery of services can result in poor outcomes in areas such as access, engagement, receptivity to treatment, help-seeking behaviors, treatment goals, and family response. Culturally competent care is an essential component to treatment. SAPC will promote cultural competency by coordinating trainings designed to educate providers and administrators about various aspects of cultural sensitivity, with the goal of better engaging patients of diverse backgrounds and needs.

Special Populations: In addition to focusing on specific practices to treat SUD, the QI program also offers guidance on treatment for patients with more complex and specialized needs such as patients with co-occurring disorders, pregnant and postpartum patients, adolescents, young adults, older adults, patients involved in the criminal justice system, homeless populations, and lesbian/gay/bisexual/transgender/questioning patients. Although some EBP have been shown to be effective when treating these populations, other clinical practices require further research (e.g., some types medication assisted treatment for adolescents). Furthermore, these populations may have special needs (e.g., history of trauma, developmental needs, co-occurring mental health conditions) that may hinder the patient's progress if not addressed as a part of treatment. Training and/or technical assistance will be necessary to ensure that staff who treat these populations have the skills to provide the best types of interventions given the patient's age, health, and other unique characteristics.

Level of Care: Level of care determinations should be based on the ASAM Criteria, which helps to organize the assessment and clinical formulation in a manner that increases the likelihood that a patient will receive the right service, at the right time, in the right setting, for the right duration. Referral to a specific level of care must be based on a comprehensive and individualized assessment of the patient, with the primary goal of placing the patient at the most appropriate level of care. In general, the preferable and most appropriate level of care is one that is the least intensive while still safely meeting the unique treatment objectives of the patient.

Recovery Support Services: Recovery support services (RSS) refer to non-clinical services that foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals. They incorporate a broad range of support and social services that facilitate recovery, wellness, and linkage to and coordination among service providers. Similar to how patients see their primary care provider for periodic health checkups even when healthy, RSS can be viewed as aftercare or continuity of care in SUD treatment. The frequency of RSS is dependent on patient need, preference, and stage of recovery.

Case Management/Care Coordination: Research suggests two main reasons why case management is effective as an adjunct to SUD treatment: 1) retention in treatment is associated with better outcomes, and a principal goal of case management is to keep patients engaged in treatment and moving toward recovery; and 2) a patient may be more likely to succeed in treatment when other problems are addressed concurrently with substance abuse. Case management and care coordination are critical aspects of treatment.

Performance and Outcomes: The QI plan includes performance and outcome measures, quality improvement projects, and a peer review process for counselors and clinicians, with the goal of

stablishing an educational and evaluative mechanism for providers to contribute to the identification of opportunities to improve care and services. Confidentiality and risk management are also addressed.

Complaints/Grievances and Appeals: A complaint/grievance and/or appeals process is available for "involved parties" (patients, their authorized representative, or providers acting on behalf of the patient and with the patient's written consent) who are dissatisfied with elements of care including, but not limited to, services, treatment, or authorization denials regarding eligibility, services, or level of care decisions. Involved parties may contact QI/UM staff in these instances to discuss their concerns. Concerns that are not adequately addressed can be elevated to formal grievances or appeals. The procedure and timetables for submitting for these processes is outlined in the full QI/UM plan.

UTILIZATION MANAGEMENT PROGRAM

The Utilization Management (UM) program helps to ensure quality services by monitoring adherence to the guidelines established within the Quality Improvement program, including processes involving eligibility and medical necessity criteria, as well as appropriate clinical care and level of care utilization.

In summary, the purpose of the UM program is to achieve the following objectives for patients and providers:

- Assure effective and efficient utilization of facilities and services through an ongoing monitoring program designed to identify patterns in under-utilization, over-utilization, and inappropriate utilization of services across the service continuum.
- Assure fair and consistent UM decision-making.
- Focus resources on a timely resolution of identified problems.
- Assist in the promotion and maintenance of optimally achievable quality of care.
- Educate health care professionals on appropriate and cost-effective use of health resources.

Initial screenings should occur at the point of first contact between a patient and the SUD system of care, whether via the Beneficiary Access Line or at the treatment provider site. Medical necessity determinations, on the other hand, will occur at the provider site via a face-to-face review or telehealth. Treatment providers should verify initial DMC-ODS eligibility and insurance status prior to the provision of services. For patients who are determined to be eligible for Medi-Cal but not enrolled, treatment providers must make efforts to enroll patients and facilitate the enrollment process.

The initial DMC-ODS eligibility determination may be performed by trained support staff and/or registered or certified SUD counselors, however medical necessity determinations must be performed by a Medical Director, licensed physician, or Licensed Practitioner of the Health Arts (LPHA): physician, registered nurse, nurse practitioner, physician assistant, licensed/waivered psychologist, licensed/waivered/registered social worker, licensed/waivered/registered marriage and family therapist, licensed/waivered/registered Licensed Professional Clinical Counselor.

Ongoing DMC-ODS eligibility will be determined by medical necessity assessment at least every six months through the reauthorization process for all SUD services other than Narcotic Treatment Program services, which will involve an annual reauthorization process. During the reauthorization process, the Medical Director, licensed physician, or LPHA at the provider agency will be required to justify ongoing eligibility for services by submitting a completed Eligibility Authorization Request Form, current treatment plan, assessment information, progress notes, and laboratory test results (if available).

Utilization Management staff will review clinical cases from SAPC contracted providers, including both adolescent and adult patients. The purpose of these case reviews is to establish an ongoing monitoring program to ensure appropriate and quality care, as well as appropriate utilization of services across the SUD service continuum.

Treatment provider caseloads for adults and adolescents at each ASAM level of care will be randomly and retrospectively reviewed on at least an annual basis, in addition to the cases that require authorization and preauthorization (described below). These case reviews are independent from SAPC contract monitoring activities, and the quantity of these reviews will occur at County discretion. Utilization Management staff may also conduct focused, retrospective chart reviews whenever concerns arise about a particular provider or patient. Such reviews may be conducted on site and without prior notice to the provider. As needed, Utilization Management and Contracts staff will confer on cases to determine the most appropriate responding SAPC entity. These cases will then be addressed, as appropriate.

The following methods of review are utilized by UM staff:
- *Prospective Review* - A prospective review occurs prior to the delivery of services.
- *Concurrent Review* - A concurrent review examines ongoing care to evaluate medical necessity, and the quality and appropriateness of care.
- *Retrospective Review* – A retrospective review examines various aspects of previously provided services.

Services requiring preauthorization are services for which the treating provider must request authorization before initiating treatment and/or before continuing care for an extension of a previous authorization. In these instances, UM staff will perform prospective reviews of care that has yet to be provided and concurrent reviews of extensions of previous authorizations, when pertinent. Clinical scenarios that require preauthorization include:
- Residential services (refer to page #61 for more details)
    - Residential preauthorizations pertain to the provision of all residential services, including youth, adults, perinatal patients, and criminal justice involved patients.
    - Residential preauthorizations are only required when initiating residential care or transitioning to a higher level of residential care (e.g., residential preauthorizations are not necessary when transition from one level of residential care to another lower level of residential care.
    - Residential services require reauthorization after 60 calendar days for all adult populations and after 30 days for youth in order to assess for appropriate level of care utilization.

Authorized services are services that require authorization from SAPC, but do not require authorization prior to the provision of services. In these instances, UM staff will perform concurrent reviews of care and extensions of previous authorizations, when pertinent. Clinical scenarios that require authorization include:
- Medication-Assisted Treatments for those under age 18 (refer to page #33 for more details)

If after careful consideration of all case information UM staff determine that the proposed and provided services are necessary, appropriate, and in accordance with standards of clinical practice outlined in the Quality Improvement program, services and reimbursement will be authorized. Denials of authorization

will be reviewed by supervisorial staff within the UM program, who were not involved in any previous level of review or decision making and who, if deciding on any of the following, are health care professionals with appropriate clinical expertise in treating the condition:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

Denials of authorization will result in denial of reimbursement for services rendered.

Denial notifications will consist of information including, but not limited to:

- The action SAPC or its contracted provider has taken and/or intends to take.
- The reasons for the action.
- The patient's right of a fair hearing.
- The procedures for exercising their rights.
- The circumstances under which expedited resolution is available and how to request it.
- The patient's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the patient may be required to pay the costs of the services.
- Any additional information needed to improve or complete the claim.

The purpose of this Executive Summary is to provide a brief overview of the QI/UM plan. If questions or concerns arise after reading this summary, please refer to the full QI/UM plan for additional details. If the full plan does not address the question/concern, please contact the SAPC.

OVERVIEW

The Substance Abuse Prevention and Control (SAPC) is a division of the Los Angeles County Department of Public Health, and is responsible for leading and facilitating the delivery of a full spectrum of prevention, treatment, and recovery support services for substance use disorders (SUD) and addiction across Los Angeles County.

Key organizational objectives are to develop a comprehensive, coordinated, and integrated continuum of care for the treatment of SUD that is accessible, evidence-based, effective, and sustainable. The Quality Improvement / Utilization Management (QI/UM) program helps to achieve these aims by providing a systematic method to oversee the quality and appropriate utilization of substance use services in Los Angeles County, and support providers in delivering timely, clinically necessary and evidence-based care.

This program plan document describes the goals, scope, structure and operations of the SAPC QI/UM program, and pertains to all providers who have contracts with SAPC to provide SUD services in Los Angeles County. The QI/UM program will be gradually phased in over a reasonable period of time.

Scope

The SAPC QI/UM plan establishes a framework for oversight that encompasses all clinical services, utilization management, and review of safety/risk management data. The QI and UM programs share complementary goals of ensuring that SUD treatment is accessible, quality-focused, evidence-based, timely, and appropriate. This objective is achieved through the routine and ongoing monitoring and evaluation of all providers who have contracts with SAPC. The continuum of SUD care provided includes: prevention, outpatient services, intensive outpatient services, residential services, withdrawal management services, and Opioid Treatment Programs (OTP). Provided services include psychosocial interventions, counseling, medication-assisted treatments, case management, care coordination, perinatal and postpartum services, physician consultation, and recovery support services.

The QI program sets standards in areas including medical necessity criteria, clinical practice, and level of care guidelines, founded on criteria established by the American Society of Addiction Medicine (ASAM).

The UM program helps to ensure quality services by monitoring adherence to the guidelines established in the QI program, including processes involving eligibility and medical necessity criteria, as well as appropriate clinical care and level of care utilization.

The purpose of the QI program is to set standards in areas including medical necessity criteria, clinical practice, and level of care guidelines, founded on criteria established by the American Society of Addiction Medicine (ASAM). Additional elements of the QI program include conducting performance improvement projects, submitting performance measurement data to the State, having mechanisms to detect under- and over-utilization of services, assess the quality and appropriateness of care furnished to patients with special health care needs, implementing a grievance and appeals process, and establishing guidelines for confidentiality and risk management, including ensuring service/billing integrity. Importantly, the QI program outlines a minimum standard and should not be construed as encompassing the totality of comprehensive SUD care provision.

Similarly, the UM program helps to ensure quality services by monitoring adherence to the guidelines established in the QI program, including processes involving eligibility and medical necessity criteria, as well as appropriate clinical care and level of care utilization. Additionally, the UM program works with the SAPC Research, Epidemiology, and Evaluation Unit to collect, maintain, and evaluate accessibility of care and waiting list information.

The SAPC QI/UM program pertains to all SUD services provided within SAPC's network of providers, and strives to work collaboratively with community providers and stakeholders, while complying with state and federal regulations and guidelines.

Given the continual evolution of the field of addiction treatment, the QI and UM programs are dynamic and will evolve with the availability of new information and research, or changes in regulatory mandates or contractual agreements. As a result, this document is subject to ongoing review and revision.

Guiding Principles

The broad objective of the QI/UM program is for patients receiving SUD services to receive effective, coordinated care that is the right service provided at the right time, at the right intensity, and for the appropriate duration. Guiding principles include:

- Support providers to help patients achieve recovery, stability, and functional improvement.
- Ensure timely access to high quality, evidence-based, medically necessary SUD services in the most appropriate setting.
- Ensure effective and efficient utilization of SUD services and resources.
- Facilitate and coordinate care between physical health, mental health, and SUD services.
- Ensure the provision of services that are age-specific and developmentally, culturally, and linguistically appropriate.
- Involve patient support systems (e.g., family members, significant others), when clinically appropriate.
- Monitor and analyze clinical performance and outcome measures to identify and promote opportunities to improve service delivery, patient outcomes, and overall organizational and provider performance.

Program Staff Structure

The SAPC QI/UM program is comprised of multidisciplinary staff that carry out their responsibilities as defined by the scope of practice of their individual professional disciplines and assigned job descriptions. The program is overseen by the Medical Director and is comprised of a multidisciplinary team including a nursing supervisor, registered nurses, clinical psychologist, research analysts, and support staff. The QI/UM program will work collaboratively with the Research, Epidemiology, and Evaluation Unit and the Clinical Standards and Training Unit within the Office of the Medical Director and Science Officer. Various departments within SAPC provide essential support, including the Director's Office, Adult and Youth Services, Information Services, Contract Services, and the Finance department. The University of California, Los Angeles Integrated Substance Abuse Program (UCLA-ISAP) will provide additional research support and training expertise.

Committee Structure

The QI/UM program is comprised of a committee structure that provides a framework for the quality improvement and oversight responsibilities of SAPC. As such, the majority of committees are internal and attended by SAPC department representatives and relevant vendors. However, there are two committees that include external stakeholders such as providers, consumers, and families, among others. The standing committees are listed below, followed by more detailed information:

- Quality Improvement / Risk Management Committee
- Utilization Management Committee
- Research and Data Management Committee
- Professional Development Committee
- Community Liaison Committee (comprised of various Sub-Committees)
- Cultural Competence Committee

A structure of standing committees will establish an organized framework to ensure quality both within SAPC and its network of providers. Relevant information from these committees will flow to the Quality Improvement / Risk Management Committee, which will be the lead committee responsible for ensuring quality-focused services and that SAPC is in a position to achieve its organizational mission.

Quality Improvement / Risk Management Committee

- The Quality Improvement / Risk Management Committee will serve as the lead committee that will be responsible for ensuring quality-focused services and that SAPC is positioned to achieve its organizational mission.
- Roles and Function:
    - Ensure patient safety and satisfaction, quality of care, and organizational efficiencies.
    - Recommend policy decisions.
    - Institute needed QI actions.
    - Ensure follow-up of QI process.
    - Review and evaluate the result of QI activities.
    - Document QI committee minutes regarding decisions and actions taken.
    - Review and update as necessary the medical necessity criteria and Clinical Practice Guidelines annually.
    - Review and monitor clinical performance indicators across all provider sites, including accessibility of services.
    - Review and approve all new provider quality improvement projects (QIPs), as needed.
    - Quarterly review of the following data:
        - Number of days to first DMC-ODS service at appropriate level of care after referral.
        - Existence of a 24/7 access line with prevalent non-English languages.
        - Access to DMC-ODS services with translation services in the prevalent non-English languages.
        - Number and percent of denied claims, and time period of authorization requests, approved or denied.
        - Data required by External Quality Review Organization (EQRO) process.
    - Oversee annual formal evaluation of QI program.
    - Review targeted clinical records, complaint/grievance and appeals filed by patients, their representatives, and/or providers.
    - Designated SAPC staff will ensure a tracking and documentation system for all reportable incidents (defined as a patient safety event that results in death, permanent harm,

and/or severe temporary harm and intervention required to sustain life), conduct investigations, and implement and follow up on corrective actions, as appropriate.
    - Oversee and monitor compliance with the applicable legal and regulatory obligations that pertain to activities performed by the SAPC QI/UM programs.
    - Identify opportunities to improve compliance and risk management processes.
    - Identify opportunities to improve QI processes and support other organizational functions.
    - Collaborate with relevant internal and external committees and parties to design, implement, and ensure feasible measurement of interventions for improving quality, care and performance.
    - Provide support to other organizational functions.
- Lead SAPC department: Office of the Medical Director and Science Officer
- Involved SAPC departments and stakeholders: Director's Office, Office of the Medical Director and Science Officer, Systems of Care (Adult & Youth), Prevention, Contract Services, Policy/Strategic Planning/Communications (PSPC), Information Systems, Finance.
- Meeting Frequency: Minimum every other month.

Utilization Management Committee
- Roles and Function:
    - Evaluate consistent use of medical necessity and review process used to approve the provision of services.
    - Evaluate consistent provision of services in accordance with clinical standards described in QI/UM program plan, and review process of determining appropriate services.
    - Review initial and ongoing eligibility determinations, and initial and continued service authorization decisions.
    - Identify and monitor under-utilization and over-utilization of services.
    - Identify and monitor utilization patterns that:
        - Compromise enrollee health and safety.
        - Inappropriately use resources.
        - Result in clinical or organizational risk.
    - Oversee annual formal evaluation of UM program.
    - Identify opportunities to improve UM processes and support quality improvement activities.
    - Provide support to other organizational functions.
    - Perform special targeted monitoring activities, as required by regional need or regulatory mandate.
- Lead SAPC department: Office of the Medical Director and Science Officer
- Involved SAPC departments and stakeholders: Office of the Medical Director and Science Officer, Systems of Care (Adult & Youth), Contract Services, Information Systems, Finance.
- Meeting Frequency: Minimum quarterly.

Research and Data Management Committee
- Roles and Function:
    - Review process of data collection and management to ensure security, effectiveness, and efficiency.
    - Collect and analyze data to ensure that data collection aligns with and informs organizational goals and priority areas of improvement.
    - Monitor accessibility of services:

        - Timeliness of first initial contact to face-to-face appointment.
        - Timeliness of services of the first dose of NTP services.
        - Access to after-hours care.
        - Responsiveness of the Beneficiary Access Line.
        - Coordination of physical and mental health services.
        - Assessment of the patients' experiences.
        - Telephone access line and services in the prevalent non-English language.
    - Identify opportunities to improve data management processes and support quality improvement activities, including the consideration of new technologies.
    - Provide guidance on quality-focused research priorities and projects.
    - Support Utilization Management Committee in performing special targeted monitoring activities related to data acquisition, as required by regional need or regulatory mandate.
    - Provide support to other departmental and organizational functions.
- Lead SAPC department: Office of the Medical Director and Science Officer
- Involved SAPC departments and stakeholders: Office of the Medical Director and Science Officer, Systems of Care (Adult & Youth), Prevention, Information Systems, PSPC, UCLA-ISAP.
- Meeting Frequency: Minimum quarterly.

Professional Development Committee

- Roles and Function:
    - Identify professional development needs of SAPC staff, based on issues and developments in the field of addiction care.
    - Review and implement educational processes to ensure continued professional development of SAPC staff.
    - Collaborate with Cultural Competence Committee regarding issues with cultural competency.
    - Collaborate with Community Liaison Committee regarding stakeholder input and concerns.
    - Provide support to other organizational functions.
- Lead SAPC department: Office of the Medical Director and Science Officer
- Involved SAPC departments and stakeholders: Office of the Medical Director and Science Officer, Systems of Care (Adult & Youth), Prevention, Contract Services, PSPC.
- Meeting Frequency: Minimum twice per year.

Community Liaison Committee

- The Community Liaison Committee will consist of an adult provider sub-committee, a youth provider sub-committee, as well as a consumer/family member sub-committee.
- **Adult Provider Sub-Committee**: Consists of the various provider meetings that are currently established (e.g., quarterly All Providers' Meeting, bimonthly [every other month] Los Angeles County Evaluation System [LACES] Advisory Workgroup meeting, quarterly Narcotic Treatment Provider meeting, quarterly CAADPE [California Association of Alcohol and Drug Program Executives] meeting, etc).
- **Youth Provider Sub-Committee**: Consists of quarterly Youth Provider meeting, etc.
- **Consumer/Family Member Sub-Committee**: Consists of consumer and family member stakeholders; will meet on a quarterly basis in rotating Service Planning Areas of the County.
- Roles and Function:
    - Promote stakeholder (consumers, families, providers, and Commission on Alcohol and Other Drugs, etc.) collaboration regarding the QI/UM process and SUD performance

measures, including feedback, addressing transparency, concerns, and ideas for future projects.
    - Report stakeholder feedback, knowledge, and suggestions to departmental and organizational leadership, as well as pertinent Committees (e.g., Professional Development Committee, Cultural Competence Committee).
    - Provide support to other organizational functions.
- Lead SAPC department: Systems of Care
- Involved SAPC departments and stakeholders: Office of the Medical Director and Science Officer, Systems of Care (Adult & Youth), Prevention, Contract Services, PSPC, UCLA-ISAP, relevant stakeholders (see above).
- Meeting Frequency: Variable.

Cultural Competence Committee
- Roles and Function:
    - Review and evaluate cultural competency of services provided to patients and their families.
    - Collaborate with the QI and UM Committees to promote cultural awareness and sensitivity.
    - Identify opportunities to improve cultural competence within the QI/UM processes.
    - Collaborate with the Professional Development Committee and Community Liaison Committee around issues with cultural competency.
    - Provide support to other organizational functions.
- Lead SAPC department: Office of the Medical Director and Science Officer
- Involved SAPC departments and stakeholders: Office of the Medical Director and Science Officer, Systems of Care (Adult & Youth), Prevention, Contract Services, PSPC, relevant stakeholder groups identified in the Community Liaison Committee. As needed: Finance and subject matter experts.
- Meeting Frequency: Minimum quarterly.

Table 1. Committee Structure Summary

Committee	Function	SAPC Dept Lead	Meeting Frequency
Quality Improvement/Risk Management*	Identify opportunities to improve quality of services, compliance and risk management, review documents (records, complaints/grievances, appeals), ensure collaboration and information exchange, and support provider-level quality improvement.	OMDSO	Every other month
Utilization Management	Evaluate use of medical necessity, provision of services, review initial / ongoing eligibility, identify and monitor over/under utilization of services and risk patterns.	OMDSO	Quarterly
Research and Data Management	Provide guidance on research priorities, identify opportunities to improve data management, support quality improvement, and consider new technologies.	OMDSO	Quarterly
Professional Development	Identify professional development needs of SAPC staff, ensure continued professional development and collaboration with other committees.	OMDSO	Twice a year

Committee	Function	SAPC Dept Lead	Meeting Frequency
Community Liaison (Adult, Youth, and Consumer/Family Member)**	Promote stakeholder collaboration regarding SAPC programming and processes, including the QI/UM process and SUD performance measures. Report stakeholder feedback, knowledge, and suggestions to departmental and organizational leadership.	System of Care	Variable
Cultural Competence**	Evaluate cultural competency and identify opportunities to improve cultural competence of services provided to patients and their families; and promote cultural awareness and sensitivity.	OMDSO	Quarterly

** Quality Improvement / Risk Management Committee serves as lead committee*
*** The Community Liaison Committee and Cultural Competence Committee will include external stakeholders such as providers, consumers, and families, among others*

OMDSO – Office of the Medical Director and Science Officer

PSPC - Policy/Strategic Planning/Communications

SAPC – Substance Abuse Prevention and Control

UCLA-ISAP – University of California Los Angeles, Integrated Substance Abuse Programs

QUALITY IMPROVEMENT PROGRAM

In light of SAPC's mission to lead and facilitate the delivery of a full spectrum of prevention, treatment and recovery support services proven to reduce the impact of substance abuse and addiction, quality improvement activities can help to ensure accessible, quality-focused, evidence-based, effective, and appropriate SUD treatment services for Los Angeles County residents.

The purpose of the QI program is to provide guidelines to ensure that the provision of services and care aligns with SAPC's organizational mission and goals, and follows generally accepted standards of clinical practice in terms of medical necessity, clinical practice, and level of care guidelines that are consistent with the ASAM Criteria. In doing so, the QI program strives to support the SAPC provider network in the provision of quality care, and to maintain programmatic, clinical, and fiscal integrity to adapt to a changing health care landscape.

The Quality Improvement / Utilization Management Program applies to all providers and patients, regardless of funding stream or modality of treatment.

The QI program conducts ongoing performance improvement projects that focus on clinical and nonclinical areas, involving:
- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve quality improvement.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

These projects are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

The QI program will implement a multi-model approach in order to achieve its objectives by utilizing the following two models: 1) Continuous Quality Improvement Model (CQI), and 2) the Chronic Care Model (CCM).

Continuous Quality Improvement (CQI)

The CQI model is a respected quality improvement model that can be employed within a behavioral health setting (see Figure 1 below).

Figure 1. Continuous Quality Improvement (CQI) Framework

The CQI model is based on concepts of quality improvement and performance measurement, and employs a patient-centered philosophy and long-term approach to provide tools to help quantify what a system should do. Additionally, this model investigates common causes for variation within a system and is driven by data, process, and patient feedback. As a result, the SAPC will continue to work with providers to monitor performance and outcomes as part of the CQI process (see Performance and Outcome Measures below). The CQI model is very similar to other cyclical approaches utilized in Public Health (Planning, Implementation, Evaluation, and Review) and is based off earlier quality improvement models of "Plan-Do-Study-Act" activities. The six steps of CQI are defined in Table 2 below:

Table 2. Six Steps of Continuous Quality Improvement

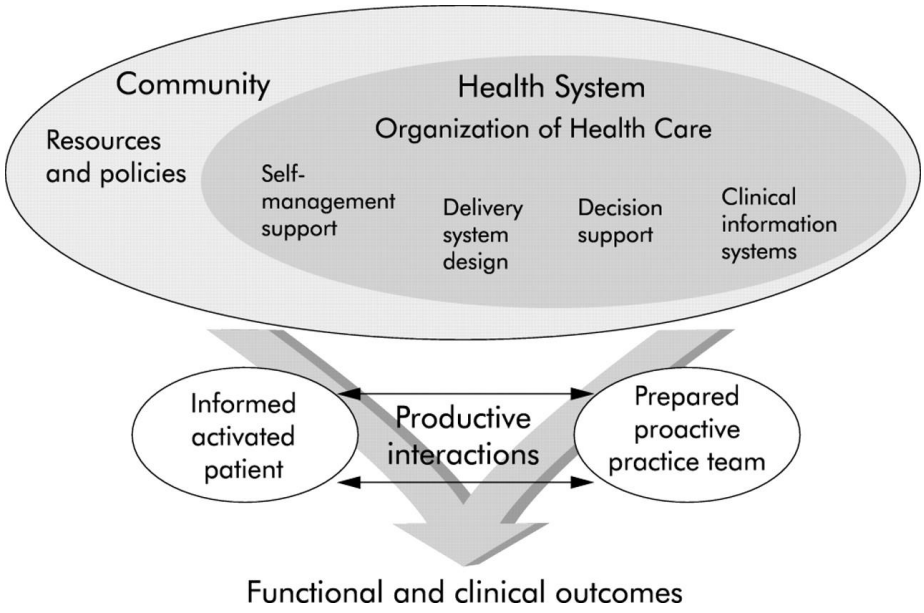
1. **Identify** a need/issue/problem and develop a problem statement.
2. **Define the current situation -** Break down problem into component parts, identify major problem areas, develop a target improvement goal.
3. **Analyze the problem -** Identify the root causes of the problem and consider using visuals, as needed.
4. **Develop an action plan -** Outline ways to correct the root causes of the problem and specific actions to be taken.

Table 2. Six Steps of Continuous Quality Improvement	
5.	**Look at the results -** Confirm that the problem and its root causes have decreased or resolved and identify if the target has been met
6.	**Start over -** Repeat process for the additional identified problems.

Chronic Care Model (CCM)

Another model that lends itself well to quality improvement in behavioral health is Wagner's "Chronic Care Model" (see Figure 2 below).

Figure 2. Chronic Care Model



According to the authors (Wagner, Austin, Davis, Hindmarsh, Schaefer, Bonomi, 2001[1]), the CCM identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. These components are described in greater detail in Table 3.

Table 3. Components of the Chronic Care Model	
1.	***Health Systems:*** Create a culture, organization and mechanisms that promote safe, high quality care. • Visibly support improvement at all levels of the organization, beginning with the senior leader

[1] Wagner, E.H., Austin, B.T., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving chronic illness care: translating evidence into action. *Health Affairs, 20 (6)*, 64-78.

Table 3. Components of the Chronic Care Model

- Promote effective improvement strategies aimed at comprehensive system change
- Encourage open and systematic handling of errors and quality problems to improve care (2003 update)
- Provide incentives based on quality of care
- Develop agreements that facilitate care coordination within and across organizations (2003 update)

2. ***Delivery System Design:*** Assure the delivery of effective, efficient clinical care and self-management support
   - Define roles and distribute tasks among team members
   - Use planned interactions to support evidence-based care
   - Provide clinical case management services for complex patients
   - Ensure regular follow-up by the care team
   - Give care that patients understand and that fits with their cultural background
3. ***Decision Support:*** Promote clinical care that is consistent with scientific evidence and patient preferences
   - Embed evidence-based guidelines into daily clinical practice
   - Share evidence-based guidelines and information with patients to encourage their participation
   - Use proven provider education methods
   - Integrate specialist expertise and primary care
4. ***Clinical Information Systems:*** Organize patient and population data to facilitate efficient and effective care
   - Provide timely reminders for providers and patients
   - Identify relevant subpopulations for proactive care
   - Facilitate individual patient care planning
   - Share information with patients and providers to coordinate care
   - Monitor performance of practice team and care system
5. ***Self-Management Support:*** Empower and prepare patients to manage their health and health care
   - Emphasize the patient's central role in managing their health
   - Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
   - Organize internal and community resources to provide ongoing self-management support to patients
6. ***The Community:*** Mobilize community resources to meet needs of patients
   - Encourage patients to participate in effective community programs
   - Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
   - Advocate for policies to improve patient care

Source: *http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18*

Effective care of chronic conditions, such as SUD, is characterized by productive interactions between activated patients, as well as their family and caregivers, and a prepared practice team. This care takes place in a health care system that utilizes community resources. At the level of clinical practice, four areas influence the ability to deliver effective chronic illness care: 1) self-management support (empower and prepare patients to manage their health and health care), 2) delivery system design (assure the delivery of effective, efficient clinical care and self-management support), 3) decision support (promote clinical care that is consistent with scientific evidence and patient preferences), and 4) clinical information systems (organize patient and population data to facilitate efficient and effective care). The end goal is to deliver care that is safe, effective, timely, patient-centered, efficient and equitable.

Access to Care

Access to care refers to the psychosocial and physical access to the location where treatment services are rendered. Physical barriers may include the architecture of the site, such as treatment providers with steps but no ramp entrance, or environmental barriers such as program location in an area where patients do not feel safe. Lack of soundproofing in counseling offices and lack of privacy in assessment rooms are also potential barriers. Psychosocial barriers may include lack of communication capabilities for hearing- or visually-impaired individuals, attitudes expressed by counselors or other staff that denote biases or communicate stigma to the patients, lack of a diverse workforce, operational hours that restrict access to services, or a lack of opportunity for patient input into his or her treatment plan or program operations. One of the central goals of the SAPC is to ensure that access to SUD treatment in Los Angeles County is timely, broad, and evidence-based.

Access to Timely Services

The Beneficiary Access Line (BAL) is available 24 hours a day, seven days a week. Patients can call the BAL to initiate a self-referral for treatment. Patients can also be referred by an organization or others, including but not limited to, physical health providers, law enforcement, family members, mental health care providers, schools, and County departments. The BAL will be capable of providing referrals to programs that specialize in treating special populations or specific cultural groups. It will also have access to additional culture-based services such as interpretation services and services for the hearing and visually impaired.

Referrals for substance use disorder (SUD) care may include SUD providers or the nearest emergency room, in cases deemed to be medical or psychiatric emergencies.

Staff at the BAL will conduct a brief DMC-ODS eligibility determination and clinical assessment for youth and adults via phone in order to determine the most appropriate referral.

The BAL will set the appointment for the initial assessment/intake with the selected provider while the beneficiary is on the call except under limited circumstances (e.g., the caller is unable to schedule, the automated appointment system is not yet developed/not working), but no longer than 3 business days from the date of the brief triage assessment. Unless the beneficiary has specific provider or other preferences (e.g., cultural/linguistic specific services) that would require a longer waiting period, the assessment/intake appointment with a qualified SUD network provider that is geographically accessible will be conducted within 15 business days from the date of the brief triage assessment. In July 2017, the assessment/intake appointment target will be 5 business days for outpatient cases and 10 business days for residential cases. In July 2018, the assessment/intake appointment target will shift to 5 business days for all levels of care.

For individuals that present at the provider site first, the same timeliness and culture-based service expectations apply and alternate referrals should be offered and documented if this cannot be achieved before placing the individual on a waitlist. Expedited or other suitable/appropriate accommodations for scheduling appointments will be made for urgent situations whenever possible. DPH-SAPC will regularly evaluate timely receipt of services, including seeking service expansion to improve the ability to receive services upon demand.

Referrals may include SUD providers or the nearest emergency room, in cases deemed to be medical or psychiatric emergencies. If referred to an SUD provider, the referral would be based off patient preference after being given various options of available providers, as well as the preliminary appropriate level of care determination.

Screening and assessment processes may occur in person, over the phone, or via telehealth. The intensity of the screening and assessment process would correspond to the clinical need, and not be so intensive that the time required for the process becomes burdensome for the patient seeking services or the SUD program providing services. Furthermore, every effort should be made to minimize the elapsed time between the initial eligibility, clinical need determination, and referral, and the first face-to-face clinical appointment.

Patients who need SUD care must be scheduled for an appointment within 3 business days and receive an appointment with their treatment provider within 15 business days. These timeframe targets will shorten in future years.

Research indicates that travel distance is linked to patient outcomes. As such, unless otherwise requested by the patient, every effort must be made to refer the patient to a treatment program that is within 30 minutes of travel time by personal or public transportation or 10 miles from the patients' location of choice. If this is not feasible, every effort should be made to decrease the likelihood that the commute or transportation issues serve as a barrier to care. If patients prefer to have some aspect of treatment delivered in a different region than where they reside or work, this preference should be noted in their clinical record.

In cases where the preliminary level of care recommendation is residential treatment but residential beds are not available, the patient will be referred to the next most appropriate level of care and a warm hand-off will be facilitated whenever necessary and feasible.

As a means to optimize access to SUD services, providers need to implement an ongoing evaluation process in order to identify barriers to treatment that may relate to the physical or psychosocial access issues mentioned above, counselor/staff attitudes around substance use, patient transportation, or any other accessibility issues. This includes considering patient and stakeholder feedback during this process to ensure adequate access to care. Once barriers are identified, providers would develop a plan detailing how they plan on addressing the identified barriers. The plan would also specify the barrier(s), the action(s) that will be taken to eliminate or reduce the impact of the barrier, and when these specific actions will be completed.

Access to Array of Services

Patients will have access to all levels of care provided by Los Angeles County including outpatient services, intensive outpatient services, residential services, withdrawal management services (only including youth on a case-by-case basis), and Opioid Treatment Program services. The SAPC will make every effort to ensure an adequate level of treatment providers for both adults and youth, based on utilization and community needs. Access to the different levels of care will be based on ASAM Criteria. As patients move through the continuum of SUD care, appropriate placement will be reassessed at each transition in treatment modality in order to ensure that the patient is placed at the appropriate level of care. Additionally, providers are expected to perform clinical assessments to determine progress on a regular basis in order to transition patients to the next appropriate level of care as soon as clinically indicated.

Emergency Services and Post-Stabilization Care

All patients must have access to emergency and crisis care for their health condition, and must be referred to appropriate facilities for these services. Preauthorization or authorization are not required for emergency services. Emergency medical and psychiatric conditions are defined as conditions with acute symptoms of sufficient severity that a prudent layperson could reasonably expect the absence of immediate care to result in placing health in serious jeopardy, serious impairment of functional status, or serious dysfunction of any bodily organ or part.

Post-stabilization care is provided after a patient is stabilized from an emergency health condition. The goal of post-stabilization care is to maintain the stabilized condition and improve the enrollee's health.

Access to Evidence-Based Services

When implemented appropriately and performed by qualified counselors and clinicians, evidence-based practices (EBP) have been proven to improve clinical care and outcomes. A number of psychosocial interventions and medication-assisted treatments are considered EBPs (see Psychosocial Interventions and Medication-Assisted Treatment sections below) and should form the foundation of a modern system for care for substance abuse.

Providers are expected to provide a minimum of two psychosocial EBPs (i.e., motivational interview and cognitive-behavioral therapy) as a component of their treatment services, in addition to supporting the use of medication-assisted treatments, when clinically appropriate. The SAPC will continue to work with treatment providers to improve the quality of clinical services and provide access to trainings on evidence-based practices.

Access to Culturally Appropriate Services

Efforts must be made to provide culturally, linguistically, and developmentally appropriate services, including, but not limited to:

- Provide a provider list of services for special populations, such as young adults, veterans, older adults, LGBTQ, etc.
- Provide culturally, linguistically, and developmentally appropriate written information in threshold languages, including information on their rights to language assistance services.
- Work to expand capacity and ability to provide a broad range of culturally, linguistically, and developmentally appropriate services.

Workforce

Recent changes in the field of addiction have led to substance use systems moving toward a chronic disease and public health model that requires a diverse, skilled, and highly trained workforce.

The SAPC recognizes and values the contributions of contract providers of all sizes and capacities, and also realizes that the composition of a successful SUD system of care must reflect the diversity of needs of the population it serves. Subsequently, the provider workforce must be either composed of or have

the capability to utilize the skills of multidisciplinary staff, all of whom are required to have appropriate experience and training at the time of hiring.

Professional clinical staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Licensed Practitioners of the Healing Arts (LPHA) include Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists (LCP), Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselors (LPCC) , and Licensed Marriage and Family Therapists (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians. Other professional staff, such as SUD counselors, and non-professional staff, must receive appropriate on-site orientation and training prior to performing assigned duties, and need to be supervised by appropriately qualified staff. Registered and certified SUD counselors must also provide services within their scope of practice and adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.

Licensed Practitioners of the Healing Arts (LPHA) include: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists (LCP), Licensed Clinical Social Workers (LCSW), Licensed Clinical Professional Counselors (LCPC), and Licensed Marriage and Family Therapists (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

Continuing education should be an integral component of professional development. The SAPC will provide training support to enhance providers' capability to deliver evidence-based, quality care. In order to maintain standards of excellence in care, patient-to-counselor ratios should allow for adequate individualized attention to ensure quality care and appropriate follow-up.

Additionally, SAPC will explore opportunities to work with provider agencies to establish a career ladder for SUD counselors based on the Substance Abuse and Mental Health Services Administration (SAMHSA) "Scopes of Practice & Career Ladder for Substance Use Disorder Counseling." Each step on the ladder requires increasing levels of education and work experience, and increasing professional responsibility (e.g., clinical supervisors). By laying out a clear career path, with increases in pay and responsibility commensurate with each step, a career ladder can help establish professional standards for the field of specialty SUD treatment and retain a qualified workforce.

Documentation

Clinical documentation refers to anything in the patients' health record (paper-based or electronic) that describes the care provided to that patient, and its rationale. It is observational and narrative in content, and is written by counselors and clinicians to analyze the process and contents of patient encounters. Clinical documentation is a critical component of quality healthcare delivery and serves multiple purposes, helping to:

- **Ensure comprehensive and quality care -** The process of writing initial assessments and proper progress notes requires thought and reflection. Preparing proper clinical documentation serves an important role of helping assure quality patient care by giving practitioners an opportunity to think about their patients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work, and weigh alternative approaches to the care. Good clinical documentation helps one organize clinical details into a case formulation that can then be used for treatment planning and is an essential element of professional practice and of the provision of quality clinical services. It

also helps to assure appropriate utilization of team members from multiple disciplines in order to leverage interdisciplinary competencies and maximize the quality of services provided.

- **Ensure an efficient way to organize and communicate with other providers -** The documentation of clinical care helps to provide structure and efficiencies to clinical communications with other providers who may be involved in the care of shared patients. This assures coordinated rather than fragmented treatment/service delivery.
- **Protect against risk and minimize liability -** Accurate and comprehensive clinical documentation is not only important in terms of quality care, but is also essential in risk management. Detailing and justifying the thought processes that contributed to the clinical decision-making process helps to support the adequacy of the clinical assessment, the appropriateness of the treatment/service plan, and demonstrates the application of professional skills and knowledge toward the provision of professional services.
- **Comply with legal, regulatory and institutional requirements –** Good clinical documentation practices help to assure compliance with recordkeeping requirements imposed by federal and state (including licensing boards) laws, regulations, and rules. It also helps to ensure that documentation meets the standards set by specific accreditation programs (e.g., CARF, Joint Commission), when applicable, and by health care institutions, facilities and agencies.
- **Facilitate quality improvement and application of utilization management –** Clinical documentation provides an opportunity to explain the process and substance of assessments, treatment and service planning, clinical decision-making, medical necessity, and the effectiveness of treatments and other services provided. As a result, it is essential for the utilization review process because clinical documentation helps to substantiate the need for further assessment, testing, treatment and/or other services, or to support changes in or termination of treatment and/or services. From a quality perspective, clinical documentation facilitates supervision, consultation, and staff/professional development, and helps to improve the quality of services by identifying problems with service delivery by providing data based upon which effective preventative or corrective actions can be taken. Appropriate recordkeeping also provides data for use in planning educational and professional development activities, policy development, program planning and research in agency settings.

Clinical documentation must be credible and complete, and is protected via the Health Insurance Portability and Accountability Act (HIPAA) and Title 42, Code of Federal Regulations (42 CFR). It encompasses every aspect of clinical care, including initial assessments, progress notes, and relevant encounters that occur outside of established appointments. Documentation of initial assessments follows the same format as the multidimensional ASAM assessment and reflects a comprehensive biopsychosocial approach. Progress notes are written during/after follow up appointments in order to gauge clinical progress and assess to determine if patient needs have changed and if modifications to the treatment approach/plan are required.

In general, clinical documentation includes the following characteristics:

- Notes that are dated, signed, and legible (if written by hand).
- Patient name and identifier are included on each page of the clinical record.
- Patient's race, ethnicity, and primary language spoken.
- Documented referral information.
- Sources of information are clearly documented.
- Patient strengths and limitations in achieving goals are noted and considered.
- The style of documentation is consistent and standardized throughout the agency/institution.

- The use of abbreviations is limited. However, when used, abbreviations are standardized and used in a consistent context.
- Documentation includes all relevant clinical information and reflects a biopsychosocial approach to the assessment process.
- Patient self-report of experiences and observed behavior is noted.
- Documentation reflects changes in patient status including response to and outcome(s) of the intervention(s) as well as progress towards goals and completion of objectives.
- Entries include the counselor's/clinician's professional assessment and continued plan of action.
- Changes in patient status are documented (e.g., change in level of care provided or discharge status).
- Describe how services provided reduced impairment, restored functioning, and/or prevented significant deterioration as outlined in the treatment plan.
- For patients with limited English proficiency, document if interpreter services were offered and provided, and an indication of the patient's response.

Patient-centered care is critical and requires that patients be provided the opportunity to actively shape their treatment plans. At a minimum, treatment plan *reviews* for adults and adolescents are required at least every 30 days and treatment plan *updates* are required at least every 90 days in outpatient, intensive outpatient, and opioid treatment program settings. For residential settings, treatment plan *updates* are required at least every 30 days, with treatment plan reviews occurring as needed and appropriate. Treatment plans in more intensive levels of care, such as residential settings, should be updated more frequently if an individual is unstable or if there is a notable event that requires a change in the treatment plan. As patients advance through treatment, the corresponding treatment plan should be reviewed and adjusted accordingly based on stability and the likelihood of rapid changes in patient condition. If a patient's condition does not show improvement at a given LOC or with a particular intervention, then a review, abbreviated assessment, and treatment plan modification should be made in order to improve therapeutic outcomes. Changing the level of care or intervention should be based on a reassessment and modification of the treatment plan in order to achieve an improved therapeutic response.

<u>Treatment Plans</u>

Treatment plans must meet the requirements specified in Title 22, CCR, Section 51341.1 (h)(2)(A), or for Opioid Treatment Programs, Title 9, CCR, Section 10305, as specified in Title 22, CCR, Section 51341.1(h)(2)(B). At a minimum, treatment plans should include:

- Thorough documentation of case details, including a diagnosis and statement of problems to be addressed.
- Goals that are mutually established between patient and provider for each identified problem.
- Action steps to be taken by the provider and/or patient in order to achieve the identified goals.
- Target dates for the achievement of identified action steps and goals.
- Description of the type(s) and frequency of services to be provided.
- Required documentation, as specified in Titles 9 and 22, including documentation of physical examinations.

- The patient shall review, approve, type or legibly print their name, sign and date the initial treatment plan, indicating whether the patient participated in preparation of the plan, within thirty (30) calendar days of signature by the counselor or provider. If the patient refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the patient to participate in treatment.
- If the LPHA determines the services in the updated treatment plan are medically necessary, the LPHA shall type or legibly print their name and, sign and date the updated treatment plan, within fifteen (15) calendar days of signature by the counselor or provider.

Standardized documentation (e.g., SOAP, GIRP, SIRP, or BIRP) increases treatment consistency, quality of care and reduces reimbursement disallowances. SAPC requires that initial documentation be based on the format of the ASAM Criteria, and that progress notes for individual and group sessions follow either the SOAP, GIRP, SIRP, or BIRP formats.

Progress Notes

For level of care transitions, initial and relevant progress note documentation are based on the ASAM Criteria and include the following information:

- Date ASAM placement criteria were used.
- Documentation of the name, location and primary contact at referral site.
- Format of ASAM criteria used (software or paper-based).
- Justification of discrepancy if the level of care suggested by ASAM criteria is not recommended by counselor/clinician.
- Justification of discrepancy if the discussed level of care is not agreeable to patient.
- Justification of discrepancy if the level of care the patient was referred to does not match the level of care suggested by the ASAM Criteria.

Progress notes must, at a minimum, be documented each day there is a patient encounter in outpatient and intensive outpatient settings. In residential settings, progress notes must be documented at least weekly by staff who have provided services for the patient during that time period.

Standardized documentation by SUD counselors and clinicians assist with increasing treatment consistency and quality of care, as well as reducing reimbursement disallowances. As such, the SAPC requires that the multidimensional components of the ASAM Criteria be incorporated into initial documentation of the first full assessment, and that progress notes for both individual and group sessions follow one of four formats: SOAP, GIRP, SIRP, or BIRP.

SOAP (Subjective, Objective, Assessment and Plan) is an acronym that describes the structure of a specific style of progress note documentation. The SOAP format is widely used and improves the quality and continuity of patient services by providing a consistent and organized framework of clinical documentation to enhance communication among health care professionals and better recall the details of each patient's case. This format allows providers to identify, prioritize and track patient problems so they can attend to them in a timely and systematic manner. It also provides an ongoing assessment of both the patient's progress and the treatment interventions. While a full review of the SOAP note format is beyond the scope of this document, below (Table 4) is a summary of its components and providers should refer to additional resources for more information.

Table 4.

SOAP Note Format	
S	**Subjective –** Patient statements that capture the theme of the session. Brief statements as quoted by the patient may be used, as well as paraphrased summaries.

SOAP Note Format	
O	**Objective –** Observable data or information supporting the subjective statement. This may include the physical appearance of the patient (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished), vital signs, results of completed lab/diagnostics tests, and medications the patient is currently taking or being prescribed.
A	**Assessment –** The counselor's or clinician's assessment of the situation, the session, and the patient's condition, prognosis, response to intervention, and progress in achieving treatment plan goals/objectives. This may also include the diagnosis with a list of symptoms and information around a differential diagnosis.
P	**Plan –** The treatment plan, based on the assessment and clinical information acquired.

The GIRP, SIRP, and BIRP progress note formats are also used to record similar clinical information in a structured format. The information included in these progress note formats includes patient goals/situation/behavior, staff interventions used during the session, patient response to the session, and the plan for future sessions or progress made toward the treatment plan. Similar to the SOAP note format, GIRP, SIRP, and BIRP notes provide a standardized structure for documentation that better ensures a comprehensive and consistent quality of care. Tables 5, 6, and 7 (below) summarize the key components of GIRP, SIRP, and BIRP progress notes, although a full review of these standardized formats is beyond the scope of this document. Providers should refer to additional resources for more detailed information.

Table 5.

GIRP Note Format	
G	**Goal –** Patient's current focus and/or short-term goal, based on the assessment and treatment plan.
I	**Intervention –** Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The patient's response to intervention and progress made toward individual plan goals and objectives.
P	**Plan** – The treatment plan moving forward, based on the clinical information acquired and the assessment.

Table 6.

SIRP Note Format	
S	**Situation –** Patient's presenting situation at the beginning of intervention. May include counselor/clinician observations, patient's subjective report and the intervention setting.
I	**Intervention –** Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The patient's response to intervention and progress made toward individual plan goals and objectives.
P	**Progress** – The treatment plan progress made toward treatment goals and objectives, as well as the plan for future interventions as determined by the clinical picture.

Table 7.

BIRP Note Format	
B	**Behavior –** Patient statements that capture the theme of the session and provider observations of the patient. Brief statements as quoted by the patient may be used, as well as

BIRP Note Format	
	paraphrased summaries that closely adhere to patient statements. Provider observations may include the physical appearance of the patient (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished, etc.), vital signs, results of completed lab/diagnostics tests, and medications the patient is currently taking or being prescribed.
I	**Intervention –** Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The patient's response to intervention and progress made toward individual plan goals and objectives.
P	**Plan** – The treatment plan moving forward, based on the clinical information acquired and the assessment.

For patients with multiple health problems, the problems can be numerically prioritized according to severity and treatment need in the plan section for the respective progress note format.

Medical Necessity Criteria

The Los Angeles County system of care and its SUD providers need to have a shared definition and understanding of medical necessity that involves diagnosis, impairment, and intervention. Medical necessity will be consistently applied to ensure equitable access to services and can be performed via a face-to-face review or telehealth by a Licensed Practitioner of the Health Arts (LPHA).

Medical Necessity Criteria:

- Patient must have at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.
- Patient must meet the ASAM Criteria definition of medical necessity for services. Medical necessity encompasses all six dimensions so that a more holistic concept would be clinical necessity, necessity of care, or clinical appropriateness. Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It must not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality).

In order to meet the medical necessity criteria:
- Patient must have at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.
- Patient must meet the ASAM Criteria definition of medical necessity for services.

Clinical Practice Guidelines

The SAPC recognizes that clinical care needs to be an individualized process that balances patient needs, established clinical standards, and available resources. Each clinical case is unique and there are many variables that impact care. However, care guidelines can be helpful to outline generally accepted clinical standards.

The guidelines outlined below are not intended to be a comprehensive overview of all aspects of clinically appropriate substance use care. It is strongly recommended that one refer to more detailed clinical guidelines provided through SAMHSA and other respected resources for additional information.

Assessment

There are various types of assessments, including initial eligibility determinations, and assessments focusing on medical necessity and clinical care, including level of care determinations. Assessments and its corresponding documentation serve as the foundation of high quality care. In the treatment of persons with SUDs, assessments are an ongoing process and are essential in order to identify patient needs and help the provider focus their services to best meet those needs. They are also an important aspect of patient engagement and treatment planning, and are generally performed in the initial phases of treatment, though not necessarily during the initial visit.

In certain situations, brief and focused assessments may be more appropriate than more extensive assessments. However, the comprehensive treatment of addictions requires a comprehensive assessment to be conducted in the initial phases of treatment. An important competency of counselors/clinicians is to discern when a brief assessment versus a comprehensive assessment is needed. Additionally, collaborative and coordinated care is a key characteristic of quality care and is based on the ability to perform appropriately comprehensive assessments in order to determine the most suitable referral or linkage.

Staff and professionals who possess the appropriate training perform assessments within their scope of practice. Comprehensive clinical assessments are performed by appropriately trained Licensed Practitioners of the Healing Arts (LPHAs) and SUD counselors.

Clinical assessments are based on the ASAM Criteria, which includes multidimensional assessments comprised of six dimensions:

1) Acute intoxication and/or withdrawal potential
2) Biomedical conditions and complications
3) Emotional, behavioral, or cognitive conditions and complications
4) Readiness to change
5) Relapse, continued use, or continued problem potential
6) Recovery/living environment

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5) Relapse, continued use, or continued problem potential.
6) Recovery/living environment.

The multidimensional ASAM assessment provides a common language to describe holistic, biopsychosocial assessment and treatment across addiction, physical health, and mental health services. At a minimum, comprehensive assessments include the following elements:

- History of the present episode
- Substance use and addictive behavior history
- Developmental history (as appropriate)
- Family history
- Medical history

- Psychiatric history
- Social history
- Spiritual history
- Physical and mental status examinations, as needed
- Comprehensive assessment of the diagnose(s) and pertinent details of the case
- Survey of assets, vulnerabilities, and supports
- Treatment recommendations

Assessments based on the ASAM Criteria ensure that necessary clinical information is obtained in order to make appropriate level of care determinations. Assessments need to be appropriately documented (see Documentation section above), reviewed, and updated on a regular basis, including at every care transition, in order to promote engagement and meet the patient's needs and preferences. If during the course of assessments the patient and provider(s) determine that adequate progress toward treatment goals has been made, plans to build upon these achievements need to be made, which may include transitions to other services and recovery-focused strategies. Similarly, reassessments of the diagnosis, treatment modalities/intensity/goals need to be performed if progress toward agreed upon goals is not being made within a reasonable time.

Patients who no longer meet medical necessity criteria for SUD treatment services, or prematurely exit the SUD system of care, should receive recovery monitoring services for a minimum of 6 months by the last treatment provider of care, who will reengage the individual in treatment if needed.

Psychosocial Interventions

Psychosocial interventions in the treatment of addictions are vital to engaging patients and promoting behavior change, and need to play an integral role in every treatment encounter. Research has shown that the longer a patient is engaged in addiction treatment, the better his or her long-term prognosis. Thus, the quality of the therapeutic alliance between patient and provider and the degree to which hope for recovery is conveyed are essential contributors to positive treatment outcomes.

Research and innovations have yielded significant progress in the development, standardization, and empirical evaluation of psychosocial treatments for SUDs. This has resulted in a wide range of effective programs for SUDs that differ in both theoretical orientation and treatment technique. While a number of approaches and techniques are effective depending on the clinical situation, certain treatment approaches have a stronger evidence base and therefore need to serve as the foundation of a high quality system of SUD care.

In Los Angeles County, although other psychosocial approaches may be used, SUD providers are at a minimum expected to implement the two evidence-based psychosocial interventions of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT). Below are descriptions of a selection of these evidence-based psychosocial interventions:

- **Motivational Interviewing (MI) -** A patient-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment by paying particular attention to the language of change. This approach frequently includes other problem solving or solution-focused strategies that build on patients' past successes. According to the Motivational

SUD providers are at a minimum expected to implement the two evidence-based psychosocial interventions of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT).

Interviewing Network of Trainers, MI "is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

- **Cognitive-Behavioral Therapy (CBT) -** According to the National Institute of Drug Abuse's *Principles of Drug Addiction Treatment: A Research-Based Guide*, "Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it. A central element of CBT is anticipating likely problems and enhancing patients' self-control by helping them develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use, and developing strategies for coping with cravings and avoiding those high-risk situations." The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.
- **Relapse Prevention -** According to SAMHSA's *National Registry of Evidence-Based Programs and Practices*, relapse prevention is "a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide patients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a patient's overall coping capacity."
- **Trauma-Informed Treatment -** According to SAMHSA's concept of a trauma-informed approach, "a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in patients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization." Seeking Safety is an example of an evidence-based trauma-informed practice.
- **Psychoeducation -** Psychoeducational interventions educate patients about substance abuse and related behaviors and consequences. The information provided may be broad, but are intended to lead to specific objectives. Psychoeducation about substance abuse is designed to have a direct application to patients' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist patients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

Elements of these psychosocial interventions may be used in any type of service setting and need to be performed by trained providers within their scope of practice. Fidelity to these evidence-based models is critical. Of note, the descriptions of the evidence-based psychosocial interventions above are simply summaries and providers are encouraged to refer to other available resources and manuals for more detailed guidance as to the effective clinical application of these approaches. Implementation of these EBPs will be a contract requirement and monitored through the contract compliance monitoring process. Corrective action ranging from technical assistance to disallowance will occur depending on the nature of the deficiency, frequency and/or severity of the findings.

Medication-Assisted Treatments (MAT)

Research has shown that for the treatment of addiction, a combination of medications and behavioral therapies is more successful than either intervention alone. Subsequently, medication-assisted treatments (MAT) need to be part of a comprehensive, whole-person approach to the treatment of SUDs that includes psychosocial interventions such as counseling, behavioral therapies, case management, and care coordination. The passive or active discouragement of the use of addiction medications that have been approved by the U.S. Food and Drug Administration (FDA) is contrary to the science of effective SUD treatment.

According to research, a combination of medications and behavioral therapies is more successful than either intervention alone. Subsequently, medication-assisted treatments (MAT) need to be part of a comprehensive, whole-person approach to the treatment of substance use disorders.

Medication-assisted treatment includes obtaining informed consent, ordering, prescribing, administering, and monitoring of all medications for SUDs. Given the biopsychosocial nature of addiction, all available clinically indicated psychosocial and pharmacological therapies need to be discussed and offered as a concurrent treatment option for appropriate individuals with an alcohol and/or opioid related SUD condition at all levels of care. When MAT is part of the treatment plan, licensed prescribers operating within their scope of practice should assist the patient to collaborate in clinical decision-making, assuring that the patient is aware of all appropriate therapeutic alternatives. Informed consent for all pharmacotherapies must be obtained, including discussion about the advantages and disadvantages of MAT, taking into consideration the benefits, side effects, alternatives, cost, availability, and potential for diversion, among other factors.

Patients receiving MAT must receive a minimum of 50 minutes of counseling sessions with a therapist or counselor, not to exceed 200 minutes per calendar month, although additional services may be provided based on medical necessity. All prescribed MAT should be consistent with generally accepted standards of medical practice and best practice guidelines for the condition being treated.

While there is not a widely agreed upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment efficacy and progress to inform treatment decisions. The frequency of drug testing should be based on the patient's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued drug use has been identified to be more common. Additionally, drug testing is best when administered randomly as opposed to being scheduled, and the method of drug testing (e.g., urine, saliva) would ideally vary as well.

There are currently several FDA-approved medications for the treatment of various types of addiction in adults:

- Opioid Use Disorder
    - Methadone
    - Buprenorphine
    - Naltrexone (oral and long-acting injectable formulation)
        - In addition to the above medications for opioid use disorder treatment, Naloxone is an FDA-approved medication used to prevent opioid overdose deaths.
- Alcohol Use Disorder
    - Naltrexone (oral and long-acting injectable formulation)
    - Disulfiram

  - Acamprosate
- Tobacco Use Disorder
  - Varenicline
  - Bupropion
  - Nicotine replacement therapy

With the exception of methadone and buprenorphine, which can be prescribed in youth age 16 and above if specific criteria are met and if they are under the treatment of a licensed prescriber, MAT is currently only FDA-approved for those over the age of 18. Current and emerging knowledge is that the routine use of MAT for adolescents is premature and requires further study. Other pharmacotherapies are used off-label for the treatment of addiction in adults and adolescents, but should be used cautiously and only on a case-by-case basis when deemed clinically appropriate by a licensed prescriber. The use and dosages of MAT should also be carefully considered in the treatment of elderly and adolescent populations, who oftentimes require unique treatment approaches given variable body composition and metabolism.

Details regarding the availability, pharmacology, and appropriate prescribing of FDA-approved medications for addiction are beyond the scope of this document. However, providers are encouraged to reference published prescribing guidelines and other available resources for additional information regarding medication-assisted treatments. The prescribing of MAT must be in compliance with all federal, state, and local laws and regulations.

Physician Consultation

Consultations with addiction-trained physicians ensure that SUD providers have access to clinical and medical information that can be used to improve care and services for addiction. These consultations will occur either telephonically or electronically, via the DPH-SAPC website or Electronic Health Record (EHR), and will not occur in real-time. Physician consultations may involve questions about medication-assisted treatments, dosage recommendations, the management of unusual or difficult cases, and level of care recommendations. Based on the best judgment of the treating providers, urgent and emergent clinical issues and questions need to be directed to appropriate emergency personnel.

Physician consultation requirements include:
- Non-urgent in nature
- Physicians practicing within the network of SAPC providers

The physician consultation service is available to Drug Medi-Cal (DMC) physicians, and is not available to non-physicians or non-DMC physicians at this time. SAPC will continue to explore opportunities to expand this service, according to community need.

Culturally Appropriate Services

Culturally competent care is critical in providing high quality SUD services. Research indicates that lack of cultural competency in the design and delivery of services can result in poor outcomes in areas such as access, engagement, receptivity to treatment, help-seeking behaviors, treatment goals, and family response.

Core practices that address cultural competency include:
- Attitudes, beliefs, values, and skills at the provider level.
- Policies and procedures that clearly state and outline the requirements for the quality and consistency of care.
- Readiness and availability of administrative structures and procedures to support such commitments.

Providing developmentally, culturally, and linguistically appropriate services is critical to quality care. Lack of cultural competency in the design and delivery of services can result in poor outcomes.

Providers are responsible for providing services that are developmentally, culturally, and linguistically appropriate, and must ensure that their policies, procedures, and practices are consistent with this requirement. Providers must also ensure that these principles are embedded in the organizational structure of their agency, as well as being upheld in day-to-day operations.

The SAPC will promote cultural competency by coordinating trainings designed to educate providers and administrators about various aspects of cultural sensitivity, with the goal of better engaging patients of diverse backgrounds and needs.

Co-Occurring Disorder Population

For the purposes of this document, co-occurring disorders (COD) are defined as when an individual has a combination of any SUD or any mental health condition. The COD must meet the diagnostic criteria independently from the other condition and cannot simply be a cluster of symptoms resulting from a single disorder. The significant co-morbidity of SUDs and mental illness (typically reported as 40% - 80% depending on study characteristics and population) and the growing body of research associating poorer outcomes with a lack of targeted treatment efforts have highlighted the importance of addressing the unique needs of this population.

As opposed to addressing health conditions separately and in silos, the ideal approach to treating co-occurring disorders is to address all conditions simultaneously.

Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. As such, integrated care broadly refers to the process of ensuring that treatment interventions for COD are combined within a primary treatment relationship or service setting. Research has generally supported that the ideal approach toward treatment for CODs is to address all conditions simultaneously, as opposed to addressing the SUD and mental health condition separately and in a silo of separate treatment approaches. When providers have staff who possess the skills and training to adequately address the needs of the COD population within their scope of practice, integrated care is best provided in-house. However, if providers are unable to provide necessary services to this population, patients with CODs should receive appropriate referrals to providers who are able to deliver these necessary services.

According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "Substance Abuse Treatment for Persons with Co-Occurring Disorders," consensus panel members recommend the following guiding principles in the treatment of patients with CODs:

- **Employ a recovery approach –** The recovery perspective essentially acknowledges that recovery is a long-term process of internal change that requires continuity of care over time, and recognizes that these internal changes proceed through various stages, and that treatment approaches need to be specific to the goals and challenges of each stage of the COD recovery process.
- **Adopt a multi-problem viewpoint –** Treatment comprehensively addresses the immediate and long-term needs of the multidimensional problems typically presented by patients with COD. (e.g., housing, work, health care, a supportive network).
- **Develop a phased approach to treatment –** Treatment phases generally include engagement, stabilization, treatment, and continuing care, which are consistent with, and parallel to, the various stages of recovery. Treatment through these phases allows providers to develop and use effective, stage-appropriate treatment interventions.
- **Address specific real-life problems early in treatment –** Given that CODs often arise in the context of social and personal problems, addressing such problems is often an important first step toward achieving patient engagement in continuing treatment.
- **Plan for the patient's cognitive and functional impairments –** Patients with COD often display cognitive and functional impairments that affect their ability to comprehend information or complete tasks. As a result, services need to be tailored to and compatible with the need and functional level of COD patients.
- **Use support systems to maintain and extend treatment effectiveness –** Given that many COD patients have strained support systems, and the central importance of supportive people and environments in the recovery process, a vital element of effective treatment of the COD population is ensuring that patients are aware of available support systems and motivated to use them effectively.

Comprehensive screening and assessments that are multidimensional in nature, combined with accurate diagnostic impressions, form the foundation of high quality integrated services. These elements are discussed in greater detail elsewhere in this document and require a strong therapeutic alliance between counselor/clinician and patient to allow for open and accurate communication. An important component of being able to develop a therapeutic alliance with the COD patient is the counselor or clinician's own comfort level in working with the patient. Some SUD counselors/clinicians may find some patients with significant mental health conditions threatening or unsettling, and likewise, some mental health clinicians may feel uncomfortable or intimidated by patients with SUDs. As a result, it is critical for the counselor/clinician to recognize these feelings so that they can develop strategies to avoid allowing them to interfere with the treatment of the COD patient. Oftentimes, these reactions can eventually be overcome with further experience, training, supervision and consultation with a supervisor or peer, and mentoring.

While SUD counselors and staff are not expected to diagnose mental health disorders, it is important that they familiarize themselves with the terminology, criteria, and how to identify if there may be mental health concerns that may benefit from referral to other health providers. In order to meet the needs of this population, SUD counselors and clinicians need to receive training designed to help them better understand the signs and symptoms of mental disorders and how and when to access medical or mental health support.

Appropriate staffing is a key element of effectively addressing the needs of the COD population. An organizational commitment to professional development, skills acquisition, values clarification, and competency attainment is necessary to implement integrated care programs successfully and to

maintain a motivated and effective staff. Ideally, enhanced staffing for COD patients at SUD treatment sites would include mental health professionals, and vice versa at mental health treatment sites.

Psychosocial interventions that have been demonstrated to be effective for the COD population include motivational enhancement, contingency management, relapse prevention, and cognitive–behavioral techniques. These strategies need to be tailored to the patient's unique stage of recovery and can be helpful even for patients whose mental disorder is severe. For patients with functional and cognitive deficits in areas such as understanding instructions, repetition and skill-building strategies can aid progress. Finally, 12-Step and other dual recovery mutual self-help groups may be valuable as a means of supporting individuals with COD, and counselors and clinicians often play an important role in facilitating participation in such groups. In general, the ability to balance the need for empathy and support, and the need to be firm, is essential in maintaining the therapeutic alliance with a patient who has a COD. A straightforward and factual presentation of conflicting material or of problematic behavior in an inquisitive and caring manner can be both "confrontational" and caring at the same time.

The use of appropriate psychotropic medications and medication-assisted treatments for addiction are an essential component of the treatment of individuals with a COD. Oftentimes the appropriate use of medications can help COD patients stabilize and control their symptoms so that they can better focus on their recovery for either their substance use or mental health conditions. Research had clearly demonstrated that medications used in conjunction with psychosocial interventions for both SUDs and mental illness is preferable and leads to better outcomes than either intervention alone. An important component of the treatment of COD patients is thus ensuring a recovery environment that is supportive of the various and individualized paths to recovery that many patients with CODs take. This includes ensuring that staff is receptive to the use of medications for both substance use and mental health conditions when determined to be necessary and appropriate by counselors and clinicians practicing within their scope of practice.

In summary, the treatment of COD patients requires a comprehensive and flexible treatment approach, in addition to coordination with other systems of care.

Perinatal (Pregnant and Postpartum) Patients

Substance use during pregnancy can result in significant maternal, fetal, and neonatal morbidity. However, research indicates that targeted interventions to pregnant women with SUDs increases the incidence of prenatal visits, improves birth outcomes, and lowers overall health care costs for both mother and baby. The unique needs of pregnant and postpartum women must be considered in the provision of services for this special population.

There is widespread agreement that treatment for pregnant and postpartum women is more effective when the services provided are wide-ranging. Care for this population needs to be interdisciplinary, comprehensive, evidence-based, and coordinated in order to best address issues related to prenatal, perinatal, and postpartum mental and physical health concerns. Psychosocial and practical issues need to be considered as well, as transportation and childcare are common barriers to treatment in this population.

Motivational therapies are critical to the engagement and recovery process. While there is overlap between treatment approaches for the general population and pregnant/postpartum patients, ideal

therapies for this special population incorporate treatment elements that are unique to this group, such as promoting bonding with the expected child, reproductive counseling, and targeted case management and care coordination to address the material and physical/mental health needs that accompany pregnancy. The initial assessment, treatment plan, and reassessments of progress need to take into account the varied needs related to the health and well-being of both woman and fetus/infant.

Ideal therapies for pregnant/postpartum patients incorporate treatment elements that are unique to this group, such as promoting bonding with the expected child or infant, reproductive counseling, and targeted case management and care coordination to address the material and physical/mental health needs that accompany pregnancy.

Federal priority guidelines for SUD treatment admission give preference to pregnant and/or female substance and injection drug users. However, a specific level of care is not prescribed and thus the appropriate setting and level of care for this population needs to be consistent with the ASAM Criteria, with consideration of the ability to accommodate the physical stresses of pregnancy (e.g., climbing stairs, performing chores, bed rest when medically required, etc.) and the need for safety and support during this period. Level of care determinations need to be based on individualized and multidimensional ASAM assessments, and may lead to placement recommendations in the residential or outpatient setting, depending on clinical need.

Staff working in settings that provide services for pregnant and postpartum patients need to be trained in proper procedures for accessing medical services related to prenatal care, labor and delivery, and therapeutic responses to the varied positive and negative outcomes of pregnancy. Services need to be provided in a non-judgmental, supportive, and open environment.

The use of medication-assisted treatments during pregnancy needs to include careful and individualized consideration of the potential impact of both treatment and lack of treatment on mother and baby. Though there is some risk in using medications during pregnancy, there is also known risk in the inadequate treatment of addiction during pregnancy, and this needs to be considered and discussed with patients. For pregnant women with opioid use disorders, medication-assisted treatments such as methadone and buprenorphine are the standard of care. In these instances, informed consent needs to be obtained, including discussions regarding Neonatal Abstinence Syndrome and what to expect at delivery. Opioid detoxification should also be reserved for selected women because of the high risk and potential consequences of relapse on both mother and baby. The risks and benefits of breastfeeding while patients are receiving medication-assisted treatments need to be weighed on an individual basis. Methadone and buprenorphine maintenance therapy are not contraindications to breastfeeding.

Given that women may be at increased risk of resuming substance use following delivery, treatment should not end with delivery. Post-delivery treatment services include, but are not limited to: support for parenting a newborn, education about breast feeding, integration with other children and family members, case management for practical needs such as legal assistance, equipment and clothing, coordination of physical and mental health services as needed, coping with the physical and psychosocial changes of the postpartum period, family planning, and encouragement of the continued pursuit of recovery goals.

Adolescent Patients

Adolescence represents an opportunity to influence risk factors that are still dynamic and not yet entrenched in their influence on development and addiction. Adolescent SUD treatment needs to be approached differently than adults because of differences in their stages of psychological, emotional, cognitive, physical, social, and moral development. Examples of these developmental issues include their relative immature independent living skills, the powerful influence of interactions between adolescent and family/peers, and the fact that a certain degree of limit-testing is a normal feature of adolescence.

Generally, optimal treatment of the adolescent population requires greater amounts of external assistance and support compared to adults, and more intensive treatment and/or higher levels of care for a given degree of severity or functional impairment, when compared with adults.

For youth, casual substance use can quickly escalate to highly problematic abuse, which highlights the importance of early invention in this population.

Although most adolescents do not develop classic physical dependence, physical deterioration, or well-defined withdrawal symptoms as is common for adults who have longer durations of substance use, adolescents may be more susceptible to the functional impact of SUDs. For youth, casual substance use can quickly escalate to highly problematic abuse. Subsequently, adolescents often exhibit higher rates of co-occurring disorders, such as anxiety and depression, because of the negative impact that substance use has on normal adolescent social and psychological development.

These unique characteristics of the adolescent population are reflected in both clinical practices as well as in the ASAM Criteria, as adolescents tend to require more intensive levels of care than their adult counterparts. As a result, the patient-to-counselor ratio for adolescent cases is ideally less than the ratio for adult cases to accommodate for this increased treatment intensity.

Due to the rapid progression of adolescent substance use, particular attention must be paid to streamlining the treatment admission process so that adolescent SUD needs are identified and addressed as soon as possible. Strategies to engage adolescents, hold their attention, channel their energy, and retain them in treatment are especially critical. Adolescent treatment needs to also address their increased rates of co-occurring disorders, highlighting the need to coordinate care with the mental health system, as clinically indicated.

Treatment planning needs to begin with a comprehensive assessment based on the ASAM Criteria. The assessment includes all the dimensions and biopsychosocial components of the complete adult assessment, the nuances of the adolescent experience, and their unique needs and developmental issues. Strengths and weaknesses need to be identified and adolescents need to be involved in setting their treatment objectives. Comprehensive adolescent assessments include information obtained from family, and when the appropriate releases are obtained, members of the community who are important to the adolescent patient, such as school counselors, peers, and mentors. The support of family members is important for an adolescent's recovery and research has shown improved outcomes for interventions that seek to strengthen family relationships by improving communication and improving family members' ability to support abstinence from drugs.

During treatment of the adolescent population, every effort needs to be made to support the adolescent's larger life needs in order to maximize the likelihood of treatment success, for example by having flexible weekend and evening hours to accommodate continued engagement with school and appropriate social activities. These larger life issues may be related to medical, psychological, and social

well-being, as well as housing, school, transportation, legal services, cultural and ethnic factors, and any special physical or behavioral issues. Failing to address such needs simultaneously could sabotage the adolescent's treatment success.

Behavioral therapies, delivered by trained counselors and clinicians practicing within their scope of practice, need to be employed to help adolescent patients strengthen their motivation to change. Effective psychosocial interventions may provide incentives for abstinence, build skills to resist and refuse substances and deal with triggers or craving, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

The use of medication-assisted treatments for adolescents is promising, but the current and emerging knowledge is that the routine use of MAT for adolescents is premature and requires further study. With the exception of methadone and buprenorphine, which can be prescribed in youth age 16 and above if specific criteria are met and if they are under the treatment of a licensed prescriber, there are currently no FDA-approved medications for the treatment of addictions in adolescents. As a result, the use of MAT for adolescents should be considered and used cautiously and only on a case-by-case basis when deemed clinically appropriate by a licensed prescriber. While most adolescents do not develop classic physical dependence or well-defined withdrawal symptoms as a result of shorter durations of substance use compared with adults, youth opioid addiction is an exception that at times may require MAT when clinically indicated, particularly for severe withdrawal symptoms.

The ASAM level of care criteria for adolescents are distinct from that of adults, and are tailored to the particular needs of this population. In general, the ASAM Criteria tends to place adolescents in more intensive levels of care than their adult counterparts.

Treatment services for adolescents occur in a setting that is clinically appropriate and comfortable for this population. The adolescent treatment environment should be physically separate from that of adult patients. Staff also need to be familiar and appropriately trained to address the developmental nuances of caring for this unique population.

Similar to other groups, treatment of the adolescent population is regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue into adulthood, with a gradual transition to adult SUD services.

Adolescent patients should be referred to a qualified adolescent/youth outpatient treatment agency where they will receive a full assessment and referral to an appropriate LOC as necessary. If the individual initially presents at a SUD treatment provider that does not offer the appropriate provisional LOC, that agency will identify alternate referral options and assist the individual in connecting with the selected agency, or the individual may elect to remain with the initial provider if clinically appropriate. All Medi-Cal eligible beneficiaries will be referred to, and/or served by, a DMC certified agency for DMC reimbursable services

Young Adult

In this document, the term "young adult" refers to individuals between the ages of 18 – 25 and represents young people transitioning into adulthood, some of whom may have received services from the adolescent service system and may need continued services and supports from the adult system.

Clinically, age range definitions should be viewed flexibly given the variable nature of chronological age and developmental maturity. This population presents unique service challenges because they are often too old for youth services, but may not be ready for adult services. Young adults are simultaneously emerging into independence while still relying on the support of parents and caregivers. The mixture of adolescent and adult characteristics in the young adult population often requires a specialized approach due to issues of confidentiality, financial support, and shared living environments, among others.

In general, the treatment needs of young adults will be more intensive than the typical adult, but less than the typical adolescent. This will require a blending of programs that currently exist for adolescents and adults, and ideally would occur within programs with specific expertise in treating this population. The approach toward caring for young adults needs to include a flexible mixture of treatment techniques depending on prior contacts with the treatment system and the unique needs of each clinical case. For young adults who have previously been served in the youth system of care for their substance use and other health needs, every effort need to be made to coordinate care with their prior providers to determine the best treatment approach. Prior response to interventions should inform and guide future interventions, with the understanding that the approach toward treatment would be dynamic as young adults transition into adulthood.

The treatment needs of young adults will generally be more intensive than the typical adult, but less intensive than the typical adolescent.

Multidimensional assessments include determinations of the developmental stage of young adult populations to help inform treatment approaches and whether care modeled after adolescent approaches or adult approaches may be more appropriate. Strengths and weaknesses need to be identified and young adults need to be involved in treatment planning. When the appropriate authorizations are obtained, family should be involved in the information gathering and treatment process, when family involvement is clinically appropriate and determined to be beneficial.

Similar to youth, young adults typically have various life needs beyond their substance use treatment, and every effort need to be made to support these needs to increase the likelihood of positive outcomes. These larger life issues may be related to medical, psychological, and social well-being, as well as housing, school, transportation, legal services, cultural and ethnic factors, and any special physical or behavioral issues.

Behavioral therapies and medication-assisted treatment, delivered by trained counselors and clinicians practicing within their scope of practice, should be employed depending on clinical need. As discussed in the Medication-Assisted Treatment section of this document, there are various medications used for addictions that have been FDA-approved for individuals over the age of 18 (and some over the age of 16), and need to be a treatment option available to young adults in conjunction with psychosocial interventions and as a component of a multifaceted treatment approach. Effective psychosocial interventions may provide incentives for abstinence, enhance motivation for change and recovery, build skills to resist and refuse substances and deal with triggers or craving, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

Ideally, staff working with the young adult population would be familiar with and interested in working with the unique needs of this population. They should have experience in treating both the adolescent and adult populations in order to best blend necessary treatment approaches.

While the ASAM Criteria does not specifically explore the specialized considerations of young adults, the ASAM Criteria does note that an intermediate stage between adolescence and adulthood may become standard in the future, with accompanying treatment approaches that are individualized to address the unique assets, vulnerabilities, and needs of this group.

Older Adults

Health care providers sometimes overlook substance use in the older adult population over the age of 65, mistaking symptoms and indications of substance use for dementia, depression, or other problems common to this population.

Given the chronic nature of substance use disorders and the expanding population of older adults, it is increasingly important to modify treatment approaches to the unique needs of this population. In general, older adults include individuals over the age of 65, but this definition should be individualized based on clinical need. For example, some individuals younger than age 65 may have cognitive deficits, medical conditions, or social situations that necessitate the utilization of treatment approaches that are more typical for individuals of more advanced age.

Key differences between older and younger populations necessitate different approaches toward treatment. Due to altered metabolism and brain function, and the medical conditions that often accompany advanced age, the quantity and frequency of substance use in older adults may underestimate the functional impact in this population and create diagnostic challenges. In addition to the fact that many older adults are retired, limiting the sensitivity of using work or social impairment as a diagnostic indicator, a smaller amount of alcohol or substances may impact older adults more severely than younger counterparts. Health care providers also sometimes overlook substance use in this population, mistaking symptoms and indications of substance use for dementia, depression, or other problems common to older adults. Social isolation, lack of transportation, and heightened levels of shame and guilt in this group may make accessing services for the older adult population more difficult than other age groups. As a result older adults may be more likely to attempt to hide their substance use and less likely to seek professional help. Older adults are also more likely to be primary caregivers for a spouse who has greater needs than their own, which may limit their willingness to enter into treatment due to their caregiving responsibilities.

Research has demonstrated that age-specific assessment and treatment is associated with improved outcomes when compared with mixed-aged treatment. Assessments need to be age-specific and multidimensional, given the various physical and mental health needs, as well as social needs, of the older adult population. The treatment of older adults needs to be paced to the individual's physical and cognitive capabilities and limitations. The schedule of programs and expectations, and the overall timeframe for clinical progression and change is typically slower for older adults than other age groups. As such, treatment programs should be realistically designed to accommodate these anticipated differences.

Studies have generally indicated that cognitive-behavioral techniques are effective for older populations, particularly those that address negative emotional states that pose significant risk for relapse (e.g., self-management approaches for overcoming depression, grief, or loneliness). In general, confrontational therapy in this population has been shown to be less effective than in other age groups and should be avoided. Educational treatment approaches should be geared toward the specific needs of older adults (e.g., coping strategies for dealing with loneliness, general problem-solving). Older adults may absorb presented information better if they are given a clear statement of the goal and purpose of

the session and an outline of the content to be covered. Repetition of educational information may also be helpful (e.g., simultaneous visual and audio).

Given that social isolation is a common problem in this population, group therapies and skill building around establishing social support networks are often beneficial, in addition to family therapy. According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "Substance Abuse Among Older Adults," consensus panel members recommend limiting involvement of family members or close associates to one or two members to avoid overwhelming or confusing older adults. Panel members also suggest that the involvement of grandchildren may lead to obstacles for open communication, as older adults may at times resent their problems being aired in the presence of younger relatives.

Medications used in older populations should be used with caution due to the physiological changes that occur with advanced age. Dosages of medications may need to be lowered, particularly if co-morbid medical conditions are involved. In cases where medications are used for withdrawal management, dosages for older populations should often be one-third to one-half the usual adult dosage. Concerns or questions regarding the safe use of medications in the older adult populations need to be directed toward appropriately trained medical professionals.

Staff working with older adults should ideally have training in aging and geriatric issues. Staff should also have an interest in working with this population and the skills required to provide age-specific services for individuals of more advanced age. The best results are typically achieved when staff is experienced in dealing with the physical, psychological, social, and spiritual issues unique to older adults. Staff who interacts with older patients need to receive regular trainings on empirically demonstrated principles and techniques effective for older populations.

In general, panelists from SAMHSA recommend the following treatment approaches for the older adult population:

- Treat older people in age-specific settings, where feasible, ensuring appropriate pace and content of treatment.
- Create a culture of respect for older patients. Follow treatment approaches that are supportive, non-confrontational, and aim to build self-esteem.
- Take a broad, flexible, holistic approach to treatment that emphasizes age- and gender-specific psychological, social, and health problems. These approaches need to include building social support networks and coping skills dealing with depression, loneliness, and loss.
- Staff working with older adults need to be interested and experienced in working with this population.

Patients Involved with the Criminal Justice System

The criminal justice system includes accused or adjudicated who require various SUD services. Parole and probation status is not a barrier to SUD treatment services provided that the parolees and probationers meet the eligibility and medical necessity criteria. For many people in need of alcohol and drug treatment, contact with the criminal justice system is their first opportunity for treatment. Services can be provided through courts, probation or parole agencies, community-based or institutional settings, or in sex offender programs. In each of these situations, the individual is accountable to comply with a criminal justice sanction. Legal incentives to enter SUD treatment at times motivate individuals to

pursue recovery, whereas for other offenders, arrest and incarceration are part of a recurring cycle of drug abuse and crime.

Ingrained patterns of maladaptive coping skills, criminal values and beliefs, and a lack of job skills may require a more intensive treatment approach for the criminal justice population, particularly among offenders with a prolonged history of substance abuse and crime. However, strong empirical evidence over the past several decades has consistently shown that the criminal justice population can be effectively treated and that SUD treatment can reduce crime.

Criminal justice patients from cultural minority groups may have unique cultural needs. For example, women offenders are more likely to have been traumatized by physical and sexual abuse and to have concerns about their children, and many offenders have co-occurring substance use and mental health conditions that can complicate treatment.

Staff working with criminal justice populations need to be specifically trained in working with criminogenic risk, need, and responsivity (RNR), as well as SUDs and CODs. Staff also need to be capable of integrating identified treatment goals with the goals of the involved agencies. As a result, it is critical for treatment providers to have a strong working relationship with probation and parole officers, judges, the court, and other legal entities involved in the patient's care.

The first step in providing SUD treatment to people under criminal justice supervision is to identify offenders in need of treatment. Comprehensive assessments incorporate issues relevant to criminal justice involved individuals, such as assessment of criminogenic RNR, anger management, impulse control, values and behaviors, family structure and functioning, criminal lifestyle, and antisocial peer relationships. Assessments also pay particular attention to CODs, developmental and cognitive disorders, and traumatic brain injury.

In general, clinical approaches and the use of medication-assisted treatments need to parallel those used with individuals who are not involved with the criminal justice system, and a qualified counselor/clinician should determine the appropriate level of placement and interventions rather than court/probation requirements. Treatment interventions need to be based on a multidimensional assessment and individualized needs. However, working with the criminal justice population does have unique requirements that necessitate modified treatment approaches in order to meet their specific needs. Additionally, it is essential to collaborate with correctional staff to ensure that the treatment goals align with correctional and supervision case planning and/or release conditions (particularly involving the prescription of certain MAT).

For example, offenders from cultural minority groups may have unique cultural needs, women offenders are more likely to have been traumatized by physical and sexual abuse and to have concerns about their children, and many offenders have co-occurring substance use and mental health conditions that can complicate treatment. Strategies to engage offender populations are especially critical. Criminal justice patients often have problems dealing with anger and hostility, and experience the stigma of being criminals, along with accompanying guilt and shame. Other groups with specific needs include older adults, violent offenders, people with disabilities, and sex offenders.

Clinical strategies for working with criminal justice patients may include interventions to address criminal thinking and provide basic problem solving skills. Providers need to be capable of using evidence-based practices designed to address SUDs, mental health, and criminogenic needs. For example, motivational interviewing, cognitive behavioral therapy that focuses on both substance use and antisocial behaviors that lead to criminal recidivism, trauma-informed care, and contingency management therapies.

Due to court mandates, classification policies and procedures, various security issues, and differences in available programming, one of the challenges of working with the criminal justice population is determining when the ASAM Criteria can be meaningfully applied. The ideal scenario is for the level of care setting to match the severity of illness and functional impairment, similar to the general population. However, there are instances in working with offenders that necessitate close collaboration with correctional staff to provide services that are clinically appropriate and that also align with correctional and supervision case planning and/or release conditions. When skillfully applied, the ASAM Criteria can be used to access the full continuum of care in a clinically appropriate manner for the criminal justice population.

Similar to other groups, treatment of offenders needs to be regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue even after the legal issues for criminal justice patients are resolved.

Homeless Population

Homelessness is an issue that impacts many individuals with SUDs as a result of the socioeconomic decline that oftentimes accompanies addictions. Conservative estimates of the prevalence of substance use among homeless individuals are approximately 20 – 35%. Although homeless patients typically require more intense treatment and have greater and more varied needs than housed individuals, homeless patients pose significant challenges to the SUD treatment community because of the various structural, interpersonal, and biopsychosocial barriers they face in accessing care. Some of these obstacles include social isolation, distrust of authorities, lack of mobility and/or transportation, and multiplicity of needs.

Services that link patients to secure housing early in treatment tend to produce better outcomes, emphasizing the importance of case management in order to meet the varied needs of homeless patients.

There is wide recognition that substance use in the homeless population cannot be treated apart from addressing the needs of the whole person in the context of his or her environment. A continuum of comprehensive services is needed to address the various safety, health, social and material needs of homeless patients. Common examples include assistance with accessing food, clothing, shelter/housing, identification papers, financial assistance and entitlements, legal aid, medical and mental health care, dental care, job training, and employment services. These services may be provided within the SUD program itself or through linkages with existing community resources. Proactive outreach, addressing needs in a non-judgmental and non-threatening environment, and addressing the various identified needs early in treatment may help to better engage this population.

On the whole, research demonstrates that effective programs for homeless patients address their substance use as well as their tangible needs (e.g., housing, employment, food, clothing, finances); are flexible and non-demanding; target the specific needs of subpopulations, such as gender, age, or diagnoses (e.g., COD/TAY/older adult populations); and provide longer-term, continuous interventions. As a result of these diverse needs, effective treatment for homeless patients must involve various disciplines and collaboration across agencies and organizations.

Stable housing is often critical to attaining treatment goals, and is an important component of necessary services. Services that link patients to secure housing early in treatment tend to produce better

outcomes, emphasizing the importance of case management in order to meet the varied needs of homeless patients.

Psychosocial interventions and MAT for homeless patients need to mirror the approaches that are successfully used in other populations, with modifications to meet the unique needs of this population. Mobile outreach services are ideal, along with motivational enhancement interventions, in order to encourage continued treatment engagement. As a whole, the homeless population tends to be less responsive to confrontational approaches to treatment. Counselors and clinicians also need to be mindful of the physical and mental health needs of this population, given high rates of co-morbidity for many homeless individuals. Medications should be used when clinically indicated, with prescribing practices that take into consideration the environment in which these medications will be used and stored (for example, care is to be taken to ensure that medications that require refrigeration are not prescribed when the patient has no way to store such medications). Integrated interventions that concurrently address the multitude of medical, psychiatric, substance use, and psychosocial needs of homeless persons tend to produce improved outcomes compared to interventions that are provided sequentially or in parallel with other services.

Successful counselors and clinicians who work with homeless patients tend to have a particular interest and comfort level in working with this challenging and rewarding population. Staff need to be experienced with the various aspects of care involved in working with homeless patients, and need to be familiar with the resources available in the community so that appropriate referrals and linkages can be made in order to best address the varied needs of patients. Ideally, care teams work collaboratively and include interdisciplinary staff comprised of medical, mental health, substance use, and social service providers.

In general, treatment for homeless patients with SUDs is challenging, but successful outcomes can be achieved by prioritizing access to appropriate housing and providing comprehensive, well-integrated, patient-centered services with uniquely qualified staff.

Lesbian, Gay, Bisexual, Transgender, Questioning Population

Lesbian, gay, bisexual, transgender, questioning (LGBTQ) populations tend to experience higher rates of substance use than the general population. The stigma and discrimination of being a member of a marginalized community such as the LGBTQ community causes some individuals to cope with these additional stressors by using substances. Furthermore, research has also shown that once LGBTQ patients do meet the criteria for a diagnosable SUD, they are less likely to seek help. These findings may be due to the various barriers the LGBTQ population faces in seeking treatment, and unique needs LGBTQ patients have that may not be addressed by SUD programs.

Substance use disorder providers need to carefully explore the individual situation and experiences of their patients, particularly in the LGBTQ (lesbian, gay, bisexual, transgender, questioning) population. Failing to do so may result in poor outcomes due to their unique circumstances and needs.

Although there are various protections in place that are intended to shield recovering substance abusers from many forms of discrimination, LGBTQ individuals are oftentimes not afforded the same protections. As a result of homophobia and/or heterosexism, some may find it difficult or uncomfortable to access treatment services and be afraid to speak openly about their sexual orientation or identity. Many LGBTQ patients may also internalize the effects of society's negative attitudes, which can result in feelings of sadness, doubt,

confusion, and fear. Problems in traditional health care systems may lead to distrust of health care professionals, requiring extra sensitivity from SUD providers.

In many ways, psychosocial and pharmacologic interventions (medication-assisted treatment) geared toward LGBTQ patients are similar to those for other groups. An integrated biopsychosocial approach takes into account the various individualized needs of the patient, including the societal effects on the patient and his/her substance use. Unless SUD providers carefully explore each patient's individual situation and experiences, they may miss important aspects of the patient's life that may affect recovery (e.g., social scenes that may contribute to substance use, prior experiences being discriminated against, a history of antigay violence and hate crimes such as verbal and physical attacks, etc).

As with any patient, substance use providers need to screen for physical and mental health conditions in LGBTQ persons due to the risk of co-morbid health conditions. As a result of previously discussed challenges confronted by the LGBTQ community, members of this group do have higher rates of certain mental health conditions and are also at greater risk for certain medical conditions. Comprehensive screening and assessments can assist LGBTQ patients in accessing appropriate care for their physical and mental health concerns.

The methods of best practice outlined in the counseling competency model apply to all populations, particularly in working with LGBTQ patients. In this model, a counselor respects the patient's frame of reference; recognize the importance of cooperation and collaboration with the patient; maintain professional objectivity; recognize the need for flexibility and be willing to adjust strategies in accordance with patient characteristics; appreciate the role and power of a counselor as a group facilitator; appreciate the appropriate use of content and process therapeutic interventions; and be non-judgmental and respectfully accepting of the patient's cultural, behavioral, and value differences.

There are also some unique aspects of treating LGBTQ patients that providers need to be aware of. While group therapies should be as inclusive as possible and should encourage each member to discuss relevant treatment issues or concerns, some group members may have negative attitudes toward LGBTQ patients. Staff members need to ensure that LGBTQ patients are treated in a therapeutic manner and group rules should make clear that homophobia is not be tolerated. The LGBTQ patient is solely responsible for deciding whether to discuss issues relating to his/her sexual orientation in mixed groups and not the other group members. Although providing individual services decreases the likelihood that heterosexism/homophobia will become an issue in the group setting, there is also an opportunity for powerful healing experiences in the group setting when LGBTQ patients experience acceptance and support from non- LGBTQ peers.

Family dynamics are also important in working with LGBTQ individuals and SUD providers need to be aware that family therapy may be difficult because of alienation owing to the patient's sexual identity. However, inclusion of family in the treatment process may also result in more positive outcomes. Given common concerns regarding living environments (in terms of recovery and safety), social isolation, employment and finances, and ongoing issues related to sexual orientation or identity, particular attention needs to be paid to discharge planning in the LGBTQ population.

Elements of treatment that promote successful treatment experiences for the LGBTQ patient include cultural sensitivity, an awareness of the impact of cultural victimization, and addressing issues of internalized shame and negative self-acceptance. Cognitive-behavioral therapies challenge internalized

negative beliefs and promote emotional regulation, which can be helpful for relapse prevention. Motivational enhancement techniques may also encourage treatment engagement in this population.

Because each patient brings his or her unique history and background into treatment, furthering our understanding of individuals different from ourselves helps to ensure that patients are treated with respect and improve the likelihood of positive outcomes. At times, SUD treatment staff may be uninformed or insensitive to LGBTQ issues, may have preconceived biases toward LGBTQ patients, or may falsely believe that sexual identity causes substance abuse or can be changed by therapy. In these cases, providers need to be aware of these beliefs in order to prevent them from becoming barriers to effective treatment of the LGBTQ patient. A substance abuse treatment program's commitment to promote sensitive care for LGBTQ patients can be included in its mission statement and administrative policies and procedures. Providing staff training and education are oftentimes valuable and include sexual orientation sensitivity training to promote better understanding of LGBTQ issues, LGBTQ -specific training, and educational programs to ensure that quality care is provided. Providers who understand and are sensitive to the issues surrounding LGBTQ issues such as culture, homophobia, heterosexism, and sexual and gender identity can help LGBTQ patients feel comfortable and safe while they start their recovery journey.

Veterans

According to U.S. Census estimates, there are over 330,000 veterans who live in Los Angeles County. Although veterans share commonalities, their experiences are as varied and unique as their needs. Some veterans may have experienced combat in one or more wars, while others may have served in non-combat roles. Likewise, some veterans may have experienced injury, including traumatic brain injuries (TBI), loss of limb, or other physical injury, while others may have emotional scars. In particular, gender may also influence veteran experiences, as reports of women veterans who have experienced sexual harassment and/or physical and sexual trauma are becoming more common. As a result of the cumulative effects of these events and experiences, veterans and family members may develop SUDs and present to treatment with a unique set of needs and circumstances that must be addressed. Under certain circumstances, veterans may be ineligible for Veteran's Administration (VA) benefits due to a dishonorable discharge or discharge "under other than honorable conditions," among other circumstances. Additionally, some veterans and family members may attempt to secure services from SUD treatment programs due to the long wait times at the VA. Regardless of the situation, SUD treatment providers should work to ensure that the services provided address the varied and unique needs of individuals.

While substances of abuse vary, veterans may abuse sedating substances such as prescription drugs in efforts to address untreated/under-treated anxiety or other mental health conditions. Additionally, co-occurring physical health conditions and injury may increase rates of prescription drug and opioid abuse, including the use of heroin, and thus certain veterans may be at higher risk for fatal overdoses and may be appropriate candidates for medication-assisted treatments.

Given the higher likelihood of trauma, physical and behavioral health complications of the veteran population, SUD providers are encouraged to perform thorough assessments that encompass the full range of complications that may be present. For example, assessments may include questions concerning trauma, combat or war experiences, or injuries that may impact the patient's participation in SUD treatment. If the patient reports (or it is determined that) injuries exist that may impact treatment,

the SUD treatment provider is encouraged to work with other providers (e.g., medical, mental health) to coordinate care, which is often particularly critical in this population.

Veterans may also have different reasons for their substance use, such as untreated/under-treated physical injury or mental health issue. Stigma is often an additional complicating issues. Although stigma exists around substance use, within the military stigma often also exists for seeking help for any health condition. Anger or personality disorders may also be present, further making treatment engagement difficult. In these instances, effectively engaging veterans and utilizing evidence-based techniques, such as motivational interviewing, will be critical to treatment success.

In summary, treatment providers may need additional training to fully understand the nuances of the veteran population and how their experiences impact their behaviors in order to adequately treat veterans and their families.

Levels of Care Guidelines

Addiction treatment is delivered across a continuum of services that reflect illness severity and the intensity of services required. One of the key goals of the SAPC is to facilitate SUD service delivery in Los Angeles County that is the right service, at the right time, for the right duration, in the right setting. While the levels of care are presented as discrete hierarchies, they need to be viewed as points along a continuum of treatment services, each of which may be provided in a variety of settings.

Referral to a specific level of care must be based on a comprehensive and individualized assessment of the patient, with the primary goal of placing the patient at the most appropriate level of care. Initial referrals may be accomplished through a brief screening tool with a more comprehensive assessment completed at the treatment program to confirm placement. In Los Angeles County, level of care determinations are based off of the ASAM Criteria, which helps to organize the assessment and clinical formulation in a manner that provides more structure and consistency in level of care determinations. In general, the preferable and most appropriate level of care is one that is the least intensive while still safely meeting the unique treatment objectives of the patient and treatment team.

Level of care determinations begin with the ASAM multidimensional assessment in order to explore patient risks, needs, strengths, skills, and resources. Dimension-specific risk ratings are generated from the assessment process and are used to help inform providers as to dimensional priorities, which are subsequently used for service planning and placement. When physical or mental health conditions are apparent, the need for immediate stabilization should be prioritized and the highest severity problem should determine the patient's entry point into the treatment continuum, whether it is within the SUD system of care (including Opioid Treatment Programs), or in the physical or mental health systems. Placement within the levels of care is best conceptualized as a flexible continuum, marked by the ASAM's five broad levels of service, each with gradations of service intensities (see Table 8 below).

Opioid Treatment Programs (OTPs; aka: Narcotic Treatment Programs) are an essential component of the continuum of care for substance use disorders. As is the expectation with other levels of SUD care, ensuring a flow of appropriate referrals between OTPs and other SUD providers, the provision of necessary services such as case management, and appropriate referrals into other health systems (if needed) are all critical to high quality OTP services. As such, the quality and resource management

standards and requirements set within the QI/UM program pertain to OTPs as well, in addition to the various State and Federal requirements that also govern the delivery of care in this setting.

Table 8.

ASAM Continuum of Care	
Level of Care	**Level**
Early Intervention	0.5
Outpatient Services	1
Intensive Outpatient / Partial Hospitalization Services - Intensive Outpatient Services - Partial Hospitalization Services	2 2.1 2.5
Residential / Inpatient Services - Clinically Managed Low-Intensity Residential Services - Clinically Managed Population-Specific High-Intensity Residential Services *Does not pertain to adolescent populations - Clinically Managed High-Intensity Residential Services - Medically Monitored Intensive Inpatient Services	3 3.1 3.3 3.5 3.7
Medically Managed Intensive Inpatient Services	4
Opioid Treatment Program (aka: Narcotic Treatment Program)	OTP

The ASAM Criteria also outlines a continuum of five levels of withdrawal management (also known as detoxification) for adults (see Table 9 below). Given that severe withdrawal is less common in adolescents than in adults, the approach to withdrawal management for adolescents is unique. When adolescent physiologic withdrawal is evident and when the clinical scenario does not require emergent care, a more integrated approach is ideal and every effort should be made to provide withdrawal management services in the setting in which adolescent patients are receiving their SUD care. Withdrawal management for adolescent populations will be handled on a case-by-case basis.

Table 9.

ASAM Continuum of Care- Withdrawal Management (ADULT)	
Withdrawal Management- Level of Care	**Level**
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM
Ambulatory Withdrawal Management with Extended On-Site Monitoring	2-WM
Clinically Managed Residential Withdrawal Management	3.2-WM
Medically Monitored Inpatient Withdrawal Management	3.7-WM
Medically Managed Intensive Inpatient Withdrawal Management	4-WM

A detailed description of ASAM level of care guidelines is beyond the scope of this document. Providers are encouraged to refer to The ASAM Criteria textbook or other helpful resources for additional information. Similarly, providers should refer to the contractual requirements of each level of care to ensure compliance with all federal, state, and local mandates. Level of care transitions should follow the relevant preauthorization and authorization protocols established in the UM program.

Services provided at the various levels of care should reflect the patient's clinical condition, including consideration for severity level and functional impairment. Interventions may include, but are not limited to: individual counseling, group counseling, family therapy, patient education, psychosocial interventions, medication-assisted treatments, collateral services, care coordination, case management,

crisis intervention, treatment planning, recovery support services (recovery monitoring/coaching, educational and vocational support, housing assistance, transportation services, peer and family support, spiritual support, etc.), and discharge services.

As patients transition between levels of service, progress in all six dimensions should be formally assessed at regular intervals, in accordance with the patient's severity level and functional impairment, as clinically indicated. These assessments help to ensure that patients are placed in the appropriate level of care and must be based on medical necessity, which need to be performed by the Medical Director, licensed physician, or LPHAs. Level of care transitions need to be based on clinical need, as opposed to funding source or programmatic need.

Continuity of care and longitudinal follow up are critical for SUD patients. Referrals and linkages to different service and levels of care within the SUD, physical, and mental health systems help to ensure that patient needs are appropriately addressed. High quality care is characterized by the seamless linking of different levels of care, both within the SUD system of care and between other systems of health care. This streamlined system of care can be achieved by care coordination, case management, role induction (preparing individuals for treatment by sharing the rationale of treatment, treatment process, and their role in that process), warm hand-offs, and assertive outreach.

In cases in which the recommended level of care is not available, which can occur due to a variety of reasons (lack of availability, funding limitations, resource constraints, etc.), the treatment plan needs to be revised in order to provide needed services in a different placement. Effectiveness and safety should be first priority in these circumstances, which may require that patients be placed in higher levels of care than the ASAM Criteria indicates. In these instances, it is the providers' responsibility to advocate for the patient and justify and explain the rationale for the alternative level of care or intervention, based on the available clinical documentation.

Recovery Support Services

Recovery is a personal process that is built on an individual's strengths, coping abilities, resources, and inherent values. Recovery should be holistic, addressing the whole person within their community. It is characterized by continual growth and improvement in one's health and wellness that may involve setbacks which are a natural part of life. Resilience and the ability to cope with adversity and adapt to challenges or change are also key components of recovery. Resilience develops over time and gives an individual the capacity not only to cope with life's challenges, but also to be better prepared for the next stressful situation.

SAMHSA has outlined four major dimensions that support a life in recovery:

- **Health** - overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being.
- **Home** - having a stable and safe place to live.
- **Purpose** - conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.

- **Community** - having relationships and social networks that provide support, friendship, love, and hope.

Recovery support services (RSS) refer to services that foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals. They are developmentally, culturally, and linguistically appropriate, and facilitate securing necessary social supports, remaining engaged in the recovery process, and living full and healthy lives in communities of their choice. They incorporate a broad range of support and social services that facilitate recovery, wellness, and linkage to and coordination among service providers, with the greater goal of improving the quality of life for people in and seeking recovery.

Recovery support services (RSS) refer to non-clinical services that foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals.

These RSS may be provided by a number of individuals, including: substance use providers, physical and mental health providers, peer providers, family members, friends and social networks, and the faith community.

The ASAM Criteria's multidimensional assessment includes Dimension 6, which assesses the recovery environment of the individual and helps to identify specific recovery needs that should be supported by RSS. Substance use providers, physical and mental health providers, peer providers, family members, friends and social networks, and the faith community may provide recovery support services. They may be provided wherever patients obtain services and can occur during treatment or as aftercare. In accordance with the chronic disease model and the fact that recovery is often a lifelong journey rather than a final destination, SUD treatment should not end when the treatment episode ends. Similar to the manner in which patients frequently see their primary care provider for periodic health checkups even when healthy, RSS can be viewed as continuity of care in SUD treatment. The frequency of RSS should be dependent on patient need, preference, and where an individual is in their stage of recovery.

Because of its individualized nature, RSS may include a number of different services and approaches:

- **Recovery Monitoring -** Recovery monitoring by recovery coaches and/or care navigators help individuals become and stay engaged in the recovery process and reduce the likelihood of relapse. These services can effectively extend the continuum of care beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery. Utilizing a recovery management model, the recovery coach or care navigator functions as the primary and ongoing point of contact for patients in order to follow up with patients on a regular basis and monitor their recovery status. As needed, recovery coaches and care navigators may provide patients with linkages to educational and job skills, housing and transportation, self-help and support, and spiritual and faith-based supports, depending on the patient's preference. Recovery coaching and/or care navigation encounters may occur via in-person meetings telephone, text messages, and/or Internet.
- **Substance Abuse Assistance -** Peer-to-peer services and relapse prevention.
- **Education and Job Skills -** Linkages to life skills, employment services, job training, and education services.
- **Family Support -** Linkages to childcare, parent education, child development support services, and family/marriage education.
- **Support Groups -** Linkages to self-help and support, spiritual and faith-based support.
- **Ancillary Services -** Linkages to housing assistance, transportation, case management, individual services coordination.

Recovery residences are a broad term describing a safe, sober, and healthy living environment that promotes recovery from alcohol and other drug use. The purpose of a recovery residence is to provide a living environment conducive to initiating and sustaining recovery. There are many different types and variations of these settings with different levels of support, providing a spectrum of housing to best meet the unique and dynamic needs of individuals across the stages of recovery. The services provided at recovery residences vary, and include peer support, group and house meetings, self-help, life skills development, treatment services (excluding treatment services that require a DHCS residential license), among other recovery-oriented services. Recovery residences must meet all zoning, fire clearance and other local requirements.

Patients who no longer meet medical necessity criteria for SUD treatment services, or prematurely exit the SUD system of care, should receive recovery monitoring services for a minimum of 6 months by the last treatment provider of care, who will reengage the individual in treatment if needed. The frequency of recovery monitoring contacts should depend on the individualized recovery situations of patients. For example, patients who have just exited SUD treatment and those at higher risk for relapse should generally receive more recovery monitoring contacts than those who have been in sustained recovery.

Case Management/Care Coordination

Case management is a coordinated approach to the delivery of health and social services, linking patients with appropriate services to address specific needs and achieve stated goals. At its core, case management should be comprised of several key functions: assessment, planning, linkage, monitoring, and advocacy.

Various members of the treatment team can function as the case manager, including registered/certified SUD counselors, social workers and Marriage and Family Therapists (MFTs), nurses, physicians, etc. Case management services may be provided face-to-face, by telephone, or by telehealth with the patient and may be provided anywhere in the community.

Research suggests two main reasons why case management is effective as an adjunct to substance abuse treatment: 1) retention in treatment is associated with better outcomes, and a principal goal of case management is to keep patients engaged in treatment and moving toward recovery; and 2) treatment may be more likely to succeed when a patient's other problems are addressed concurrently with substance abuse.

In order to link patients with services and resources (e.g., financial, medical, or community services), case managers must have a working knowledge of the appropriate services needed for the patient to optimize care through effective, relevant networks of support. Case managers provide assistance with accessing transportation, securing safe housing, and looking for potential employment and vocational training opportunities, particularly in geographic locations convenient for the patient. Skill development services help the patient learn how to budget, plan meals, practice hygiene and personal care, and perform housekeeping. Services provided through case management are thus tailored to facilitate continuity of care across all systems of care, and provide extensive assessment and documentation of the patient's progress toward self-management and autonomy.

Case managers must have a working knowledge of the appropriate services needed for the patient to optimize care through effective, relevant networks of support.

Although an important component of case management in the SUD population is linking patients to outside systems of care, such as physical and mental health systems, these services are equally important in navigating patients through the SUD system of care. Comprehensive substance abuse treatment often requires that patients move to different levels of care within the SUD continuum, and case managers helps to facilitate those transitions. When implemented to its fullest, case management enhances the scope of addiction treatment and the recovery continuum.

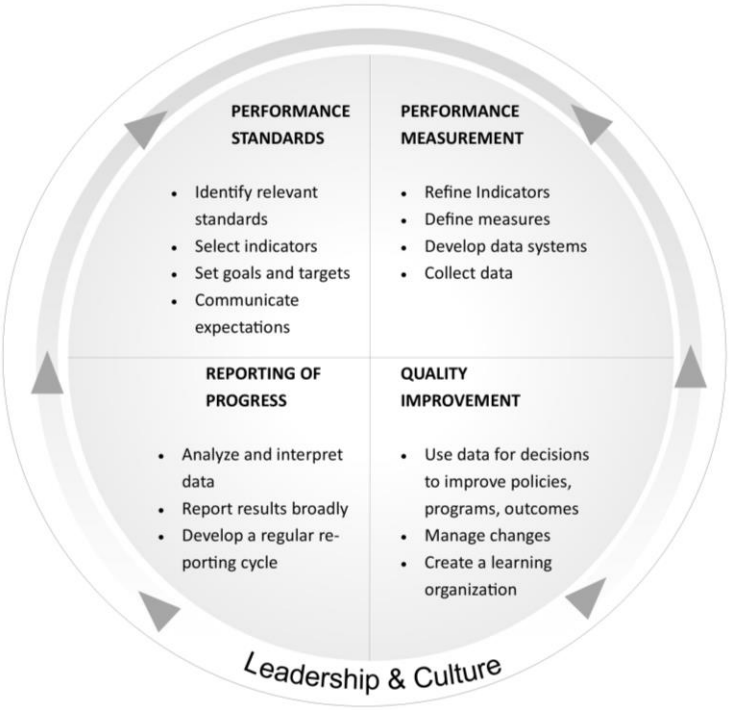
Guiding principles of comprehensive case management include:

- Comprehensive assessments and periodic reassessments of patients to determine service needs.
- Aiding in transitions in care, both within the SUD system of care and between physical and mental health systems.
- Ensuring ongoing source of primary care.
- Using a patient-centered, collaborative approach to address the medical, psychosocial, behavioral, and spiritual needs of the patient, and improve treatment retention.
- Promoting advocacy, shared decision-making, and education by moving the individual to self-management and autonomy through community resources and linkages.
- Participating in communication, coordination, referral and related activities.
- Coordinating services furnished to a patient with services the patient receives from any other plan.
- Sharing the results of assessment with plans serving a patient with special health care needs to prevent duplication of activities.
- Using culturally competent and evidence-based practices in the daily practice of case management.
- Promoting quality outcomes that measure and improve patient safety, satisfaction and other dimensions of optimal health and well-being.
- Protecting privacy in accordance with the privacy requirements
- Maintaining and reinforcing compliance with federal, state, local rules and regulations.

Performance and Outcome Measures

Healthcare providers, including SUD providers, share the common goal of providing high quality care. Measuring performance and outcomes help organizations and providers understand how well they are accomplishing this goal and allows for an analysis of where and what changes need to be made in the process of striving for continual improvement. Providers are required by contract to have ongoing mechanisms for quality assessment and performance improvement. Metrics also allow providers to understand what is working well so that others can learn from their success. Assessing and evaluating performance and outcome measures is consistent with the Department of Public Health's Performance Management System (see Figure 3 below).

Figure 3. **Public Health Performance Management System**



Importantly, performance and outcome measurement differ as follows:

- Outcome measures are used at the patient level to examine changes in substance use behaviors and psychosocial functioning. They are used to understand the effectiveness of treatment services in improving substance use and related functioning of *individuals* who have received treatment.
- Performance measures are used at the program level to evaluate how well a program is doing in achieving standards of quality, and can help identify where service problems exist, which programs are meeting or exceeding expectations of treatment quality, and what, if any, changes should be made to improve service delivery. They inform quality improvement strategies aimed at changing *clinical practices* and *organizational cost management*.

The process of striving for quality and continual improvement is dependent on the ability to measure performance and outcomes.

Although the SAPC recognizes that performance and outcome measurement in the field of addiction is challenging due to the nuances of clinical care that are not always reflected in the measures, and that consensus standards need to continue to improve, there is also a recognition of the important role that this will play in moving the field ahead. As a result, the SAPC has worked with UCLA and stakeholders to develop an inventory of measures that will be used as part of the Continuous Quality Improvement (CQI) process. The SUD Measure Inventory below (Table 10) includes a compilation of performance and outcome measures that are derived from national experts on quality improvement and performance measurement, such as the National Quality Forum, National Committee on Quality Assurance, The Washington Circle, and UCLA, among others.

The SUD Measure Inventory includes performance and outcome measures that highlight key areas of interest, such as prevention, detection, access, treatment, care continuity, integrated care, patient-centered care, -assisted treatment, functional improvement, and agency level metrics. To address patient perception of care (patient satisfaction), SAPC will use the Modular Survey developed by the

Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment. The survey measures consumer perceptions of their experience during treatment in the area of access, quality, social connectedness, and commitment to change.

In addition to these more clinical measures, the SAPC has also worked with UCLA and stakeholders to develop a set of research measures that allow for the review of treatment data in order to identify areas that require additional study, training, or technical assistance. These research measures, in conjunction with the SUD Measure Inventory, help to ensure that Los Angeles County has an evaluation system that allows for continuous improvement and high quality clinical care at the provider and systems level.

The SAPC will work to automate the data collection process to the extent that is possible, but data entered by providers will continue to be critical to ensure high quality data. Given that this data will inform policy and ultimately impact clinical practice, ensuring data integrity is to the benefit of both the SAPC and contracted providers, and providers are expected to develop internal processes to support data integrity efforts.

The SAPC recognizes the importance of sharing performance and outcomes data with its provider network, and will make every effort to provide metrics to assist providers in their quality improvement efforts. The sharing of performance and outcomes data with providers will include patient satisfaction information and other meaningful issues that pertain to clinical care.

Given the continual evolution of the field of addiction treatment, the SUD Measure Inventory will evolve with the availability of new information and research, and is subject to ongoing review.

Table 10. Substance Use Disorder (SUD) Measure Inventory

ALCOHOL AND OTHER DRUGS (AOD)

Domain	Measure Title	Measure Description
TBD	TBD	TBD

TOBACCO

Domain	Measure Title	Measure Description
TBD	TBD	TBD

Peer Review

Provider agencies must incorporate peer reviews into their continuous quality improvement activities, and establish a formal process for regularly identifying processes or variations in care/services that may lead to undesirable or unanticipated events affecting patients or clinical care. The goal of the peer review process is to establish an educational and evaluative mechanism for providers to contribute to the identification of opportunities to improve care and services.

As a component of the peer review process, SUD counselors/clinicians of various disciplines review their colleagues' patient charts and provide feedback on the care that is recommended and provided, in a professional and non-adversarial manner. Reviews should be performed by practitioners within their appropriate scope of practice, and when possible, supervisors should review and follow up with counselors/clinicians in order to provide feedback based on the peer review process. Analyses of clinical decisions and practices should be based, as appropriate, on objective evidence drawn from relevant scientific literature, clinical practice guidelines, departmental historical experience and expectations, peer department experience and standards, and national standards.

The goal of the peer review process is to establish an educational and evaluative mechanism for providers to contribute to the identification of opportunities to improve care and services.

The focus of these reviews may vary depending on needs determined by the provider agency, and may highlight an individual event or aggregate data and information on clinical practices. However, at a minimum, peer reviews must include:

- Review of diagnosis/diagnoses and assessment(s).
- Review of documentation clarity and organization.
- Ensure treatment plans are documented and updated accordingly.
- Ensure documentation is signed by appropriate individuals.

The quantity and frequency of reviews may also vary depending on needs determined by the provider agency for each site, but no less than three (3) patient charts for each counselor/clinician must be reviewed twice annually.

All records and information obtained during peer review functions should remain confidential and be used only for the purpose of reviewing the quality and appropriateness of care for improved practices.

Quality Improvement Projects

A quality improvement project (QIP) is a concentrated effort on an identified problem in one area of a provider agency. It involves gathering information systematically to clarify issues or problems, and intervening for improvements. The purpose of QIPs is to examine and improve care or services in high-priority areas that the agency identifies as needing attention, which will vary depending on variables including, but not limited to, the population served, workforce, and unique scope and capabilities of services provided. The QIP is not meant to replace other quality improvement projects that organizations may already be using, which may be used or adapted to qualify as their QIP.

All QIPs should follow the Continuous Quality Improvement model and target improvement in relevant areas of clinical care, either directly or indirectly. Areas of focus may include improving access to and availability of services, improving continuity and coordination of care, improving the quality of specific interventions, enhancing service provider effectiveness, etc. Generally, a clinical issue selected for study should impact a significant portion of the patient population served and have a potentially significant impact on health, functional status or satisfaction. Over time, areas selected for improvement focus should address a broad spectrum of care and services.

Each provider agency must be involved in at least one QIP at all times, and these projects and their evolution will be reviewed on an annual basis by SAPC staff.

Confidentiality

All programs must operate in accordance with legal and ethical standards. Federal and state laws and regulations protect the confidentiality of patient records maintained by all SAPC contracted providers. Maintaining appropriate confidentiality is of paramount importance. All SAPC contracted providers are required by contract to establish policies and procedures regarding confidentiality and must ensure compliance with Title 42, Chapter I, Subchapter A, Part 2 of the Code of Federal Regulations, Part 2 (42 CFR Part 2), the Health Insurance Portability and Accountability Act (HIPAA) standards, and California State law regarding confidentiality for information disclosure of alcohol and drug use, and other medical records.

HIPAA and 42 CFR Part 2 both cover what information can be disclosed with and without patient permission, as well as exceptions to confidentiality (e.g., emergency care, evaluation, research and audit activities).

- For a summary of 42 CFR Part 2, please see: http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2 - se42.1.2_131
- Subpart A includes an introduction to the statute (e.g., purpose, criminal penalty, reports of violations, etc).
- Subpart B covers general provisions (e.g., definitions, confidentiality restrictions, and minor patients, etc).
- Subpart C covers disclosures allowed with the patients' consent (e.g., prohibition on re-disclosure, disclosures permitted with written consent, disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs, etc).
- Subpart D covers disclosures that do not require patient consent (e.g., medical emergencies, research, evaluation and audit activities).
- And Subpart E includes information on court orders around disclosure (e.g., legal effects of order confidential communications, etc).
- A summary of the HIPAA privacy rule can be found here: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html. For more general information on HIPAA, please see: http://www.hhs.gov/ocr/privacy/index.html. For more specific information concerning covered entities, consumer information and health information technology, please see http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html.

These laws and regulations must not be used as barriers to provide coordinated and integrated care. Provided that the appropriate patient releases and/or consents for treatment are obtained, every effort should be made to share clinical information with relevant providers across the continuum of SUD care, and also across systems of care (physical and mental health, etc). Within the requirements of the laws and regulations governing confidentiality in the provision of health services, all SAPC contracted providers must cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information for the purposes of improving the effectiveness, integration, and quality of health services.

Risk Management

Risk management refers to strategies that minimize the possibility of an adverse outcome or a loss, and maximize the realization of opportunities. Good risk management techniques improve the quality of patient care and reduce the probability of an adverse outcome and resulting liability to the health care provider. Standards of care, quality improvement, and the systematic gathering, analysis, and utilization of data are the foundations of risk management.

The SAPC recognizes the growing need and importance of risk management strategies in an evolving health care landscape. As a result, each provider agency contracted to provide services by SAPC is responsible for investigating and reporting on specific functions and aspects of care dealing with risk management issues, including reviewing reportable incidents and adverse events, verifying service/billing integrity, and establishing peer review processes among service providers.

Good risk management techniques improve the quality of patient care and reduce the probability of an adverse outcome and resulting liability to the health care provider.

Adverse events are defined as incidents that have a direct or indirect impact on the community, patients, staff, and/or the provider agency as a whole need to be investigated and evaluated at the provider agency level. This information should be used on a routine basis to improve accessibility, health and safety, and address other pertinent risk management issues. The functions and responsibilities of the providers' Risk Management Committee should be systematic and ongoing to include appropriate and timely responses for addressing areas of concern or deficiency.

Reportable incidents are patient safety events that result in death, permanent harm, and/or severe temporary harm, and intervention required to sustain life. Reportable incidents must be investigated by the provider's Risk Management Committee, and must be reported to the SAPC Quality Improvement/ Risk Management Committee immediately. These incidents may result in corrective actions and are viewed as learning opportunities to improve care and risk management processes.

While reportable incidents must be reported to the SAPC Quality Improvement/Risk Management Committee, adverse events and other risk management and quality-related issues may be reported to the SAPC at the discretion of the leadership of contracted providers.

Overall, the functions and responsibilities of the providers' Risk Management Committee should be systematic and ongoing to include appropriate and timely responses for addressing areas of concern or deficiency. The goals of the provider Risk Management Committees may include:

- To assure implementation of an agency-wide safety program that includes development of policies and procedures, and subsequent staff trainings, relating to quality improvement, fire safety, disaster preparedness, hazard reporting, etc.
- To assure a tracking and documentation system for all reportable incidents, including follow up and implementation of any corrective action until follow up is no longer indicated.
- To review safety and incident related data and to identify trends and patterns associated with risks or to identify problem areas.
- To investigate adverse events, as necessary and appropriate.
- To provide thorough investigation on all reportable incidents, which must be reported to the SAPC.
- To establish processes to maintain service/billing integrity and quality care, including peer review processes for service providers.

- To promote quality improvement activity through identifying opportunities towards maximizing safety of physical and therapeutic environment and reducing agency, staff, and patient risks.

Complaints/Grievances and Appeals Process

A complaint/grievance and appeals process is available for patients, their authorized representative, or providers acting on behalf of the patient and with the patient's written consent ("involved parties").

A complaint or grievance process is available for patients, their authorized representative, or providers ("involved parties") who are dissatisfied with elements of care including, but not limited to, quality of care, services, and/or treatment.

An appeals process is also available for patients or involved parties to challenge authorization denials regarding eligibility, services, or level of care decisions.

An "appeal" refers to a request for review of an "action," which includes:
- Denial or limited authorization of a requested service such as the type or level of service.
- Denial, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to provide services in a timely manner, as defined by the State.
- Failure of the SAPC to act within the specified timeframes.
- Denial of a request to obtain services outside of the network.

A "grievance" or complaint refers to an expression of dissatisfaction about any matter other than an "action," as defined above. Possible subjects for complaints/grievances include, but are not limited to: the quality of care of services provided; aspects of the interpersonal relationships such as rudeness of a provider or employee; and failure to respect the patient's rights.

Involved parties may contact QI/UM staff in these instances to discuss their concerns. In many cases, a responsible and reasonable resolution can be achieved through an informal and professional discussion. However, additional action in the form of a complaint/grievance or appeal may be required in some instances. Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution. The QI/UM program, Finance Unit, or the Contract Unit is responsible for processing these complaints/grievances and appeals, depending on the nature of the situation and the responsibilities of the respective unit.

The SAPC will provide patients reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

At the agency level, providers must have policies and procedures in place for collecting, reviewing, and acting on complaints/grievances/appeals that are filed by their patients. This process should be clear and transparent to all patients and providers, and should be integrated into the quality improvement processes of the provider agency.

Similarly, patients, their authorized representative, or providers acting on behalf of the patient and with the patient's written consent have the opportunity to file a complaint/grievance and/or appeal. Involved parties may review and respond to the evidence and rationale provided by QI/UM staff in instances of denials of authorization, and may challenge denials of eligibility or authorizations for levels of care.

Complaint/Grievance Process

- Complaints/grievances may be initiated by phone or in writing by submitting a completed Complaint/Grievance/Appeal Form to QI/UM staff, either via web application, fax, or mail within thirty (30) calendar days of the reason for filing the complaint/grievance. See below for contact information.
    - Complaints/grievances initiated by phone must be followed by a completed and signed Complaint/Grievance/Appeal form.
- Upon receipt, complaints/grievances will be logged by QI/UM staff and an acknowledgement letter will be sent to the requesting party within five (5) calendar days of receipt of the complaint/grievance.
- The staff making decisions on grievances/appeals will not have been involved in any previous level of review or decision making, and if deciding on any of the following, are health care professionals with appropriate clinical expertise in treating the condition:
    - An appeal of a denial that is based on lack of medical necessity.
    - A grievance regarding denial of expedited resolution of an appeal.
    - A grievance or appeal that involves clinical issues.
- Patients and/or providers are entitled to a full and fair review conducted by QI/UM staff that possess the appropriate clinical expertise.
- All complaints/grievances will be reviewed by supervisorial staff within the QI/UM program, who will work with QI/UM staff and the involved party/parties filing the complaint/grievance to research all facts associated with these inquiries and conduct additional research, such as contacting the treating provider, if necessary. Every attempt will be made to achieve a satisfactory resolution, if applicable.
- A decision regarding the grievance will be rendered within the timeframes listed in Table 11, though many complaints/grievances will be addressed sooner. If the complaint/grievance cannot be resolved within the respective timeframe, an extension of fourteen (14) days may be granted by the QI/UM supervisor.
    - Decision notifications will include, but not be limited to:
        - The date and result of the grievance.
        - Reasons and rationale for decision (if decision result in denial).
        - Contact information for the reviewer.
        - Information regarding the state fair hearing process and the patient's right to continue to receive benefits while the fair hearing is pending.
    - In instances in which appeals are denied and not wholly resolved in favor of the patient, patients must be notified of:
        - The right to request a State fair hearing and how to do so.
        - The right to request to receive benefits while the hearing is pending, and how to make the request.
        - The possibility the patient may be held liable for the cost of those benefits if the State fair hearing decision upholds the original denial decision.
- Complaints/grievances will be addressed as a component of the quality improvement activities within the QI program, and depending on the nature of the complaint/grievance, may trigger more targeted follow up at the provider level.
- Concerns that arise during the complaint/grievance process will be discussed with providers and are viewed as a learning opportunity for both QI/UM staff and SAPC contracted providers, with the shared goal of improving our system of SUD care.

Complaint/Grievance is a process of expressing dissatisfaction with elements of care including, but not limited to, quality of care, services, treatment, and/or authorization decisions.

- Complaints/grievances may be presented to the Quality Improvement / Risk Management Committee during its meetings every other month in order to identify trends, areas needing process or performance improvement, and determine necessary action steps.

Appeal Process

- Utilization management decision makers are not incentivized or rewarded to issue denials, and encouraging under-utilization of services is contrary to the organizational mission and goals of the SAPC.
- Appeals offer an opportunity for additional review and reconsideration of denial decisions in instances in which patients, their authorized representative, or providers may disagree with the decisions rendered by UM staff. In these circumstances, parties may file a formal appeal to challenge denials of eligibility, level of care decisions, or payment for services.
- Patients and/or providers are entitled to a full and fair review. Appeals reviewers will consist of supervisorial and/or higher management staff.
- Appeals can be submitted in writing by forwarding a completed Complaint/Grievance/Appeal Form to QI/UM staff, either via web application, fax, or mail within 30 (thirty) calendar days from the date of the written decision notification for the authorization request. See below for contact information.
- Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the patient or the provider requests expedited resolution.
- The patient or provider may file an appeal either orally or in writing, and unless he or she request expedited resolution, must follow an oral filing with a written, signed, appeal.
- Upon receipt, appeals will be logged by QI/UM staff and an acknowledgement letter will be sent to the requesting party within the timeframes outlined in Table 11.
- Staff reviewing the appeal request will research the facts associated with the initial denial and conduct additional research, such as contacting the treating provider, if necessary. Reviewers will also consult the ASAM Criteria and/or other appropriate clinical resources.
- The patient is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The SAPC will inform the patient of the limited time available for this in the case of expedited resolution.
- After careful consideration of all case information, a decision will be rendered and the rationale and outcome will be conveyed to the appealing patient and/or provider, in accordance with the timeframes outlined in Table 11. If the complaint/grievance cannot be resolved within the respective timeframe, an extension of fourteen (14) days may be granted by the QI/UM supervisor.
    - Decision notifications include, but are not limited to:
        - The date and result of the appeal.
        - Reasons and rationale for decision (if decision result in denial).
        - Contact information for the reviewer.
        - Information regarding the state fair hearing process and the patient's right to continue to receive benefits while the fair hearing is pending.
    - In instances in which appeals are denied and not wholly resolved in favor of the patient, patients must be notified of:
        - The right to request a State fair hearing and how to do so.
        - The right to request to receive benefits while the hearing is pending, and how to make the request.

If patients, their authorized representative, or providers disagree with the decisions rendered by UM staff, a formal appeal can be filed in order to challenge a denial of eligibility, level of care decision, or payment for services. Appeals offer an opportunity for additional review and reconsideration of denial decisions.

        - The possibility the patient may be held liable for the cost of those benefits if the State fair hearing decision upholds the original denial decision.
- Appeals for initial residential authorizations and medication-assisted treatment for youth under age 18 will be expedited, according to the timeframes outlined in Table 11, whereas residential reauthorizations will follow the standard appeal timeframe.
- The expedited resolution of appeals begins when the SAPC determines (for a request from the patient) or the provider indicates (in making the request on the patient's behalf) that taking the time for a standard resolution could seriously jeopardize the patient's life, health, or functional status. The provider agency will be notified within the timeframe listed in Table 11 below.
- The patient and his or her representative should have an opportunity, before and during the appeals process, to examine the patient's case file, including medical records, and any other documents and records considered during the appeals process.
- Concerns that arise during the appeals process will be discussed with providers, may result in corrective actions, and are viewed as a learning opportunity for both QI/UM staff and SAPC contracted providers, with the shared goal of improving our system of SUD care.
- Appeals will be presented to the Quality Improvement / Risk Management Committee during its meetings every other month in order to identify trends, areas needing process or performance improvement, and determine necessary action steps.
- During the appeal process, the patient continues to receive his or her benefits if:
    - The enrollee or the provider files the appeal in a timely manner, defined as filing on or before the later of the following: within ten (10) days of the SAPC mailing the notice of action; or the intended effective date of the SAPC's proposed action.
    - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
    - The services were ordered by an authorized provider.
    - The original period covered by the original authorization has not expired.
    - The patient requests extension of benefits.
- If, at the patient's request, the SAPC continues or reinstates the patient's benefits while the appeal is pending, the benefits must be continued until one of following occurs:
    - The patient withdraws the appeal.
    - Ten (10) days pass after the SAPC mails the notice, providing the resolution of the appeal against the patient, unless the patient, within the ten (10) day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
    - A State fair hearing office issues a hearing decision adverse to the patient (e.g., denial).
    - The time period or service limits of a previously authorized service has been met.
- Patient responsibility for services furnished while the appeal is pending.
    - If the final resolution of the appeal is adverse to the patient (e.g., denial) and upholds the SAPC's action, the SAPC may recover the cost of the services furnished to the patient while the appeal is pending, to the extent they were furnished solely because of the appeal.
    - If the SAPC or State fair hearing reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the SAPC must authorize and provide the disputed services promptly.
    - If the SAPC or State fair hearing office reverses a decision to deny authorization of services, and the patient received the disputed services while the appeal was pending, the SAPC must pay for those services.

Contact Information:
County of Los Angeles, Department of Public Health
Substance Abuse Prevention and Control
Office of the Medical Director and Science Officer
1000 South Fremont Avenue; Building A-9 East, 3rd Floor
Alhambra, California 91803
XXX-XXX-XXXX

In all cases, patients who have exhausted the Complaint/Grievance and/or Appeals process, may request a State fair hearing process with the California Department of Health Care Services.

Table 11. Complaint, Grievance, and Appeal Notification Timeframes

Description	Receipt Notification	Decision Notification	Written Decision Notification
Complaint/Grievance A process of expressing dissatisfaction with elements of care including, but not limited to, quality of care, services, and/or treatment. * Must be filed within thirty (30) calendar days of the reason for filing the complaint/grievance.	Within three (3) calendar days of receipt of complaint / grievance	Within seven (7) calendar days of receipt of complaint / grievance	Within thirty (30) calendar days of receipt of complaint/grievance
Expedited Appeal for Initial Residential Authorizations and Medication-Assisted Treatment for Youth Under Age 18	Within two (2) business days of appeal	If a request for expedited resolution of an appeal is denied, it is transferred to the timeframe for standard resolution and reasonable efforts to provide the patient prompt oral notice of the denial	Within two (2) business days
		Within three (3) business days of receipt of appeal	Within seven (7) business days of receipt of appeal request
Standard Appeal for Residential Reauthorizations, Grievance Decisions, etc.	Within three (3) calendar days of appeal	Within twenty-one (21) calendar days of receipt of appeal	Within forty-five (45) calendar days of receipt of appeal request

Description	Receipt Notification	Decision Notification	Written Decision Notification
Formal process of challenging authorization denials regarding eligibility, services, or level of care decisions. * Must be filed within thirty (30) calendar days from the date on the written decision notification.			

Note: These timeframes may be extended by up to an additional fourteen (14) calendar days if:

- The patient or the provider, requests extension;
- The SAPC justifies (to the State agency upon request) a need for additional information and how the extension is in the patient's interest.

For any extension not requested by the patient, SAPC would provide the patient or provider written notice of the reason for the delay and inform the involved parties of the right to file a grievance if he/she disagrees with that decision. The SAPC will issue and carry out its determination as expeditiously as the patient's health condition requires and no later than the date the extension expires.

UTILIZATION MANAGEMENT PROGRAM

The Utilization Management (UM) program analyzes how the SAPC provider network is delivering services and how it is utilizing resources for eligible patients. The various responsibilities of the UM program include: ensuring adherence to established eligibility and medical necessity criteria; ensuring that clinical care and ASAM level of care guidelines are followed; monitoring both under- and over-utilization of services; assessing the quality and appropriateness of care furnished to enrollees with special health care needs; conducting clinical case reviews (prospective/concurrent/retrospective) of requests for select services; authorization of select services; random and retrospective monitoring of a portion of provider caseloads; and ongoing monitoring and analysis of provider network service utilization trends.

SAPC follows federal and state decision and notification timeframes for all UM determinations.

In summary, the purpose of the UM program is to achieve the following objectives for patients and providers:

- To assure effective and efficient utilization of facilities and services through an ongoing monitoring program designed to identify patterns in under-utilization, over-utilization, and inappropriate utilization of services across the service continuum.
- To assure fair and consistent UM decision-making.
- To focus resources on a timely resolution of identified problems.
- To assist in the promotion and maintenance of optimally achievable quality of care.
- To educate health care professionals on appropriate and cost-effective use of health care resources.

The SAPC follows federal and state decision and notification timeframes for all UM determinations. The SAPC will make every effort to complete UM determinations expeditiously in order to facilitate timely treatment for the patients served in the system of SUD care in Los Angeles County, and to assure compliance with all requirements.

Eligibility and Medical Necessity Review Process

Initial eligibility determinations should occur at the point of first contact between a patient and the SUD system of care, whether it be the Beneficiary Access Line or at the treatment provider site. Medical necessity determinations will occur at the provider site. The initial eligibility determination may be performed by trained support staff and/or registered or certified SUD counselors, however medical necessity determinations must be performed by a Medical Director, licensed physician, or Licensed Practitioner of the Health Arts (LPHA) (see Workforce section above).

Initial eligibility requirements for patients:
- Resides within Los Angeles County.
- Must be enrolled in Medi-Cal.
- Must meet medical necessity criteria.

Initial eligibility determinations may be performed by trained support staff and/or registered or certified SUD counselors, however medical necessity determinations must be performed by a Medical Director, licensed physician, or Licensed Practitioner of the Health Arts (LPHA).

Medical necessity eligibility requirements for patients:
- Must have one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.
- Must meet the ASAM Criteria definition of medical necessity for services. Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It must not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality).

Benefits for SUD services shall be available to all patients who meet the requirements of the eligibility and medical necessity criteria listed above. Legal status (e.g., parole, probation) is not a barrier to access substance use services, provided that the prospective patient meets the specified eligibility and medical necessity requirement.

Eligibility will be determined at least every six months through the reauthorization process for all SUD services other than Narcotic Treatment Program services, which will involve an annual reauthorization process. During the reauthorization process, the Medical Director, licensed physician, or LPHA at the provider agency will be required to justify ongoing eligibility for services by submitting a completed Authorization Request Form, current treatment plan, assessment information, progress notes, and laboratory test results (if available). All documentation should be submitted at least 21 calendar days in advance of end date of current eligibility authorization in order to prevent the disruption of reimbursable services. The provider agency will be notified of the eligibility reauthorization decision within the timeframe listed in Table 12.

After the initial eligibility and medical necessity determination, UM staff will perform a patient case review in situations that require authorization or preauthorization in order to verify that these criteria have been met prior to payment for services. For other cases that do not require authorization or preauthorization, as a component of the UM program, a random retrospective review of a portion of all provider caseloads will also ensure fidelity to eligibility and medical necessity criteria.

Utilization management staff have the authority to approve services and reimbursement. If the decision is outside the scope of the UM staff member's authority, the case will be referred to UM management and/or the Medical Director for a determination.

Information for case reviews is obtained from a variety of sources. Although each case is unique, these sources of information may include, but are not limited to, information from the patient or responsible family member, patient record, substance use providers, physical/mental health providers, etc. Utilization Management staff will use this information, along with clinical judgment, departmental policies and procedures, needs of the patient, recommendations from providers, and characteristics of the system of care, to render a decision about the provision of SUD services, as needed.

If UM staff determines that eligibility and medical necessity criteria have been met, and the proposed or provided services are deemed clinically appropriate, services and reimbursement will be authorized and the applying agency will be notified in accordance with the notification timeframes listed in Table 12. Reimbursements for services will be retroactive to the date of the referral submission, pending case review and approval.

If UM staff render a denial determination for eligibility and medical necessity, the case will be reviewed by supervisorial staff within the UM program. If the decision is consistent with the original denial, the applying agency will be notified of the decision within the timeframes listed in Table 12. Adverse eligibility and medical necessity determinations will result in denial of reimbursement for services rendered. Denial notifications will include information including, but not limited to:

- Reason(s) including specific plan provisions, clinical judgment used.
- Any additional information needed to improve or complete the claim.
- Descriptions of the appeal process.

Patients, or providers acting on behalf of the patient, have the opportunity to review and respond to the evidence and rationale outlined in the initial denial, and may challenge a denial of eligibility, coverage of services, or denial of payment for services (see Grievances and Appeal Process)

Table 12. Utilization Management Notification Timeframes

Review Type	Email/Verbal Decision Notification	Written Decision Notification
INITIAL AUTHORIZATIONS		
Initial Authorization for Eligibility and Medical Necessity – Non-Residential Services	Within one (1) business day of receipt of request	Within five (5) calendar days of receipt of request
Initial Preauthorization for Services and Eligibility – Residential Services	Within twenty-four (24) hours of receipt of request	Within five (5) calendar days of receipt of request
Initial Authorization for Authorized Service – Medication-Assisted Treatment for Those Under Age 18	Within five (5) calendar days of receipt of authorization request	Within seven (7) calendar days of receipt of authorization request
RE-AUTHORIZATIONS		
Re-Authorization for Eligibility and Medical Necessity– Non-Residential Services	Within fourteen (14) calendar days of receipt of re-	Within twenty-one (21) calendar days of receipt of re-authorization request for

Review Type	Email/Verbal Decision Notification	Written Decision Notification
INITIAL AUTHORIZATIONS		
* Must submit re-authorization request at least twenty-one (21) calendar days in advance of end date of current authorization	authorization request for Eligibility and Medical Necessity	Eligibility and Medical necessity
Re-authorization of Residential Services and Medication Assisted Treatment for Those Under Age 18 ** Must submit re-authorization request at least seven (7) calendar days in advance of end date of current authorization	Within five (5) calendar days of receipt of re-authorization request	Within seven (7) calendar days of receipt of re-authorization request
EXPEDITED AUTHORIZATIONS		
If provider indicates or the UM team determines, that following the standard timeframe could seriously jeopardize the patient's life, health, or functional status	As expeditiously as the patient's health condition requires and no later than three (3) working days	N/A

Note: These timeframes may be extended by up to an additional fourteen (14) calendar days if:

- The patient or the provider, requests extension;
- The SAPC justifies (to the State agency upon request) a need for additional information and how the extension is in the patient's interest.

Clinical Case Review Process

Utilization Management staff will review clinical cases from SAPC providers, including both adolescent and adult patients. The purpose of these case reviews is to establish an ongoing monitoring program to ensure appropriate and quality care, as well as appropriate utilization of services across the SUD service continuum. In some instances, these reviews are related to reimbursement of services and in others, the reviews are important and necessary to ensure the quality and appropriateness of services provided. Providers contracted to provide services with SAPC are required to cooperate with all case reviews conducted by the UM program.

Multidisciplinary UM reviewers will possess appropriate clinical expertise to evaluate the case and will conduct thorough case analyses, assess for appropriate care that is consistent with generally accepted standards of clinical practice, and determine appropriate utilization of services and resources to ensure that patient needs are met. Reviewers will conduct additional research, discuss the case with the requesting provider when appropriate, and consult the ASAM Criteria and/or other appropriate resources.

Information for case reviews is obtained from a variety of sources. Although each case is unique, these sources of information may include, but are not limited to, information from the patient or responsible family member, patient record, substance use providers, physical/mental health providers, etc. Utilization Management staff will use this information, along with clinical judgment, departmental policies and procedures, needs of the patient, recommendations from providers, and characteristics of the local delivery system, to render a decision about the provision of SUD services.

Utilization Management staff will review clinical cases from SAPC's network of providers in order to establish an ongoing monitoring program to ensure appropriate and quality care, as well as appropriate utilization of services across the service continuum.

Case review considerations include, but are not limited to:

- Patient/family/guardian identified goals and preferences.
- Care/service is necessary and clinically appropriate in terms of level of care, intervention, frequency, timing, and duration, and considered effective to promote recovery.
- Care/service is consistent with generally accepted standards of clinical practice based on:
    - Credible scientific evidence published in peer-reviewed medical literature that is generally recognized by independent clinical experts at the time the services are provided.
    - Recommendations of a physician-specialty society.
    - The DSM and ASAM Criteria.
    - Case discussions with treating providers, when appropriate.
    - Any other relevant factors.
- Case management to ensure that care/service is coordinated both across the continuum of SUD care and across relevant physical and mental health systems, as clinically indicated.
- Regular patient assessments ensure that care/service is provided in the least restrictive, most cost-effective environment that is consistent with clinical standards of care.
- Care/service is not provided solely for the convenience of the provider, recipient, recipient's family, or custodian (e.g., placing patients in a residential level of care primarily for housing purposes).
- Care/service is not experimental, investigational, and/or unproven.
- Care/service is deemed necessary and furnished by or under the supervision of an appropriate and authorized licensed practitioner, and in accordance with all applicable rules, regulations, and other applicable federal, state, and local directives.

Provider caseloads for adults and adolescents at each ASAM level of care will be randomly and retrospectively reviewed on at least an annual basis, in addition to the cases that require authorization and preauthorization (described below). These case reviews are independent from SAPC contract monitoring activities, and the quantity of these reviews will occur at County discretion. Utilization Management staff may also conduct focused, retrospective chart reviews whenever concerns arise about a particular provider or patient. Such reviews may be conducted on site and without prior notice to the provider. As needed, Utilization Management and Contracts staff will confer on cases to determine the most appropriate responding SAPC entity. These cases will then be addressed, as appropriate.

Reportable incidents (defined as a patient safety event that results in death, permanent harm, and/or severe temporary harm and intervention required to sustain life) must be reported to the SAPC for further investigation, in accordance with State requirements. The SAPC recognizes the importance of flexibility in clinical decision-making and the individualized nature of each unique patient case. Concerns

that arise will be discussed with providers and are viewed as learning opportunities for both the SAPC and its providers, with the shared goal of improving our system of SUD care.

The following methods of review are utilized by UM staff:

- **Prospective Review -** A prospective review occurs prior to the delivery of the services and applies to an initial request or for services that require authorization. The prospective review is performed by UM reviewers, who apply pre-established medical necessity/appropriateness criteria and render a decision on approval or denial of authorization and/or reimbursement.
    - Prospective reviews allow for the opportunity to assure the efficient and appropriate provision of care and utilization of resources, and to continually assess and improve access and quality of care.
    - Example of prospective review:
        - Preauthorization of residential services.
        - Preauthorization of MAT for patients under age 18.
- **Concurrent Review -** A concurrent review examines ongoing care to evaluate medical necessity, and the quality and appropriateness of care. This review is conducted by UM reviewers, in accordance with pre-established criteria, as previously mentioned.
    - The main objectives of the concurrent review process are to ensure that care is appropriate and in accordance with generally accepted standards of practice, to continually monitor patient progress, and to anticipate treatment needs and transitions that promote recovery.
    - Example of concurrent review:
        - Reauthorization of ongoing residential services.
        - Reauthorization of ongoing MAT for patients under age 18.
- **Retrospective Review -** Retrospective reviews examine various aspects of previously provided services. These reviews yield information about the quality of eligibility determinations and service authorization decisions, and other aspects associated with the services provided to patients. This information is used to evaluate the quality and appropriateness of the services the provider is contracted to deliver. Open and closed cases may be identified for retrospective review through numerous mechanisms.
    - Retrospective reviews allow for the opportunity to identify under- and over-utilization of services, to identify utilization patterns and trends, to continually evaluate the consistency of the UM review and decision-making process, and to continually identify areas of improvement.
    - Example of retrospective review:
        - Random, focused chart review of services that have already been rendered to ensure fidelity to eligibility and medical necessity criteria, as well as quality of care.

The UM program utilizes a variety of methods of review when performing case reviews to monitor care quality and appropriateness, and to inform decisions regarding eligibility, coverage of services, and authorizing reimbursements. Given the complications that can result from the denial of retrospective reviews after the provision of services by providers, whenever possible, prospective and concurrent reviews are preferable to retrospective reviews. The timely submission of authorization requests by providers is helpful in minimizing the potential complications and financial impact of retrospective review denials, and is therefore beneficial to the submitting provider.

<u>Preauthorization</u>

Services requiring preauthorization are services for which the treating provider must request approval before initiating treatment. In these instances, UM staff will perform prospective reviews of care that has yet to be provided and concurrent reviews of extensions of previous authorizations, when pertinent.

The provider will be required to notify UM staff of the recommended services via web application or fax in order to begin the preauthorization review process. Notifications from providers must, at a minimum, include a completed Authorization Request Form and initial intake documentation, including assessment information. Requests for continuation of services that require preauthorization must be submitted at least 7 calendar days in advance of the end date of current authorization, and required documentation includes, at a minimum, a completed Authorization Request Form, current treatment plan, assessment information, and progress notes, and laboratory test results (if available).

Utilization Management staff will perform clinical reviews of the case being referred for preauthorization, based on the case review considerations listed above. Approval for initial preauthorization requests is based on medical necessity and ASAM Level of Care guidelines, as well as generally accepted standards of clinical practice. Consideration for ongoing authorization is based on the same criteria, as well as documented progress and engagement in treatment.

Services that require preauthorization, such as residential services, are services for which the treating provider must request approval before initiating treatment and/or before continuing care for an extension of a previous authorization.

If a decision determination cannot be made due to insufficient documentation, UM staff will return the authorization request and notify the provider that additional information is needed to process the request.

For services that require preauthorization, notifications will occur within the prospective and concurrent review timeframes specified in Table 12.

Clinical scenarios that require preauthorization, and relevant service-specific details, include:

- **Residential services (adults and youth):**
    - The provider will submit a preauthorization request to the UM unit, which will conduct a prospective review, and then approve or deny the request within 24 hours of receiving the request. If relapse risk is deemed to be significant without immediate placement in residential care, a residential treatment provider may admit an individual prior to receiving residential authorization, with the understanding that authorization denials will result in financial loss, whereas authorization approvals will be retroactively reimbursed to the date of admission.
    - Requests for continuation of residential services must be submitted at least 7 calendar days in advance of the end date of current authorization.
    - Residential preauthorizations pertain to the provision of all residential services, including youth, adults, perinatal patients, and criminal justice involved patients.
    - Residential preauthorization is only required when initiating residential care or transitioning to a higher level of residential care. Preauthorization for residential services is not necessary if transitioning to a lower level of residential care.
    - Residential lengths of stay:
        - Adults
            - For adults, there will be a maximum residential treatment limit of 90 days in one continuous period, unless medical necessity warrants a one-time extension of up to 30 days on an annual basis. Only one extension of up to 30 days beyond the maximum length of stay of 90 days may be authorized for one continuous

length of stay in a one-year period (365 days). For both adult and adolescent populations, only two non-continuous 90 day regimens will be authorized in a one-year period.

- Residential services for all adult populations require reauthorization after 60 calendar days to assess for appropriate level of care utilization.

- Adolescents
  - For adolescents, there will be a maximum residential treatment limit of 30 days in one continuous period, unless medical necessity warrants a one-time extension of up to 30 days on an annual basis. Only one extension of up to 30 days beyond the maximum length of stay of 90 days may be authorized for one continuous length of stay in a one-year period (365 days). For both adult and adolescent populations, only two non-continuous 90 day regimens will be authorized in a one-year period.
  - Youth residential services require reauthorization after 30 calendar days to assess for appropriate level of care utilization.
  - In general, adolescents require shorter lengths of stay and should be stabilized and then moved down to a less intensive level of care.
- Perinatal clients
  - Following initial residential preauthorization, perinatal clients may be authorized for extensions of residential services every 30 days up to the length of the pregnancy and postpartum period, which is 60 days after the pregnancy ends, based on medical necessity.
- Criminal justice clients
  - Following initial residential preauthorization, criminal justice clients may be authorized for extensions of residential services every 30 days up to 6-months or longer based on medical necessity.

- Residential patients must receive regular assessments of their progress within their 60- and 30 calendar day residential authorizations for adult and youth populations, respectively. Given the fluid nature of clinical progression, the expectation will be that clinical progress note assessments are performed on a regular basis during residential treatment as clinically warranted and that certain patients will not require the full period of authorized residential services. In these instances, patients must be transitioned to a lower level of care as soon as clinically indicated. Required treatment plan updates every 30 days in the residential setting will help to facilitate these regular case reviews to ensure that patients receive care in the least restrictive setting that is clinically appropriate. Please see the Documentation section for additional details on treatment plan requirements.
- If upon clinical review, either during a focused or random retrospective review, an ongoing residential treatment case is determined to be unnecessary based on the aforementioned considerations, UM staff will have the authority to terminate/modify the current authorization and to deny ongoing reimbursement for residential services, and require transition to an appropriate lower level of care. In these instances, reimbursement for residential services that have already been provided will be maintained, but future reimbursement for the identified episode will be denied. Providers will be responsible for ensuring successful care coordination during all level of care transitions.

- Providers will be required to notify UM staff of residential discharges and to submit a completed discharge summary within 24 hours.

Authorization

Authorized services are services that require approval from SAPC, but do not require authorization prior to the provision of services. In these instances, UM staff will perform concurrent reviews of care and extensions of previous authorizations, when pertinent.

The provider will be required to notify UM staff of the recommended services within 3 calendar days via web application or fax in order to begin the authorization review process. Notifications from providers must, at a minimum, include a completed Authorization Request Form and initial intake documentation, including assessment information. Required documentation for requests for continuation of authorized services must, at a minimum, include a completed Authorization Request Form, current treatment plan, assessment information, progress notes, and laboratory test results (if available).

Utilization Management staff will perform clinical reviews of the case being referred for authorization, based on the case review considerations listed above. Approval for initial authorization requests is based on medical necessity and ASAM Level of Care guidelines, as well as generally accepted standards of clinical practice. Consideration for ongoing authorization is based on the same criteria, as well as documented progress and engagement in treatment. For services that require authorization, notifications will occur within the review timeframes specified in Table 12.

Clinical scenarios that require authorization, and relevant service-specific details, include:

- **Medication-Assisted Treatment for individuals under age 18:**
  - Individuals under the age of 18 who initiate medication-assisted treatment (MAT). Re-authorization required every 30 calendar days, until age 18, if the clinical determination is that patients under age 18 require ongoing MAT.
  - Requests for continuation of MAT for individuals under age 18 must be submitted at least 7 calendar days in advance of the end date of current authorization.

Table 13. Preauthorized and Authorized Services

Service Type	Initial Service Request Timeframe	Ongoing Service Request Timeframe	Notification Timeframe	Reauthorization Timeframe
PREAUTHORIZED SERVICES				
Residential Services	Preauthorization must be submitted prior to service delivery	Re-authorization request must be submitted at least seven (7) calendar days in advance of end date of current authorization	See Table 12	Re-authorization required after sixty (60) calendar days for adults, and thirty (30) calendar days for youth, as clinically indicated (see above for residential lengths for stay for specific populations)
AUTHORIZED SERVICES				

Medication-assisted treatment for individuals under age 18	Authorization must be submitted within three (3) calendar days of initiation of service	Re-authorization request must be submitted at least seven (7) calendar days in advance of end date of current authorization	See Table 12	Re-authorization required every thirty (30) calendar days until age 18, or as clinically indicated

A summary of services that require preauthorization and authorization is included in Table 13.

If after careful consideration of all case information UM staff determine that the proposed and provided services are necessary, appropriate, and in accordance with standards of clinical practice outlined in the QI program, services and reimbursement will be authorized and the applying provider will be notified in accordance with the notification timeframes listed in Table 12. Reimbursements for services will be retroactive to the date of the referral submission, pending case review and approval.

Denials of authorization will result in denial of reimbursement for services rendered and will be reviewed by supervisorial staff within the UM program and if the decision is consistent with the original denial, the applying agency will be notified of the decision within the timeframes listed in Table 12. Denials of authorization will result in denial of reimbursement for services rendered. Denial notifications will include information including, but not limited to:

- The action the SAPC has taken or intends to take.
- The reasons for the action.
- The patient's or the provider's right to file an appeal.
- The patient's right of a State fair hearing.
- The procedures for exercising the patient's rights.
- The circumstances under which expedited resolution is available and how to request it.
- The patient's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the patient may be required to pay the costs of the services.

Patients, or providers acting on behalf of the patient, have the opportunity to review and respond to the evidence and rationale outlined in the initial denial, and may challenge a denial of eligibility, coverage of services, or denial of payment for services (see Complaints/Grievances and Appeal Process).

APPENDIX

Provider Staff Roles and Responsibilities

Responsibilities	Provider's Medical Director	Licensed Physician	LPHA	Registered / Certified SUD Counselors	Trained Support Staff
Initial Eligibility Determination	✓	✓	✓	✓	✓
Clinical Assessments	✓	✓	✓	✓	
Medical Necessity	✓	✓	✓		
Reauthorization	✓	✓	✓		
Filing Appeals	✓	✓	✓	✓	
Case Management	✓	✓	✓	✓	

Licensed Practitioner of the Health Arts (LPHA): Licensed Practitioner of the Health Arts (LPHA), which includes the following:

- Physician
- Registered Nurse
- Nurse Practitioner
- Physician Assistant
- Psychologist (Licensed/Waivered)
- Social Worker (Licensed/Waivered/Registered)
- Marriage And Family Therapist (Licensed/Waivered/Registered)
- Licensed Professional Clinical Counselor (Licensed/Waivered/Registered)
- Registered Pharmacist

These LPHAs must provide services within their individual scope of practice and receive supervision required under their respective scope of practice laws.

GLOSSARY

American Society of Addiction Medicine - **(ASAM)** - The ASAM is a professional society representing physicians and associated professionals dedicated to increasing access and improving the quality of addiction treatment. The ASAM Criteria is a set of guidelines for assessing and making placement decisions for patients with addiction and co-occurring conditions.

Beneficiary Access Line (BAL) - Centralized screening and referral service that is available 24 hours a day, seven days a week. Patients can call the BAL to initiate a self-referral for treatment or can also be referred by an organization or others, including but not limited to, physical health providers, law enforcement, family members, mental health care providers, schools, and County departments.

Care Coordination - The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.

Commission on Accreditation of Rehabilitation Facilities (CARF) - An independent, nonprofit accreditor of health and human services whose mission it is to "*promote the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement services that center on enhancing the lives of persons served*."

Case Management - A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

Chronic Care Model (CCM) - A well-established organizational framework for chronic care management and practice improvement that identifies the six essential elements of a health care system that encourage high-quality chronic disease care: organizational support, clinical information systems, delivery system design, decision support, self-management support, and community resources.

Cognitive Behavioral Therapy (CBT) - A type of psychotherapy that is evidence-based and uses strategies based on the theory that learning processes play a critical role in the development of maladaptive behavioral patterns. Cognitive behavioral therapy focuses on examining the relationships between thoughts, feelings and behaviors.

Clinical Practice Guidelines - Recommendations for counselors/clinicians about the care of patients with specific conditions, which should be based on the best available research evidence and practice experience.

Co-occurring Disorders (COD) - Describes the presence of two or more health conditions at the same time. For example, a person may have a substance use disorder as well as a mental health condition, or a substance use disorder as well as a physical health condition.

Continuum of Care - A concept involving an integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensities of care.

Continuous Quality Improvement (CQI) - An approach to quality management that is based on concepts of quality improvement and performance measurement, and encourages health care team members to continuously identify opportunities for improvement. It employs a patient-centered philosophy and long-term approach to provide tools to help quantify and inform program planning.

Diagnostic and Statistical Manual of Mental Disorders (DSM) - The standard classification of mental disorders used by a wide range of health and mental health professionals.

Evidence-Based Practice (EBP) - A clinical approach that applies the best available research results to inform health care decisions. Health care professionals who perform evidence-based practice use research evidence along with clinical expertise and patient preferences.

Licensed Clinical Social Worker (LCSW) - Professionals that have either a masters or doctoral level degree in social work, and licensure or professional supervision that allows them to provide counseling and psychotherapy from a social work orientation. They are qualified to assess, diagnose and treat mental and emotional conditions and addictions.

Licensed Mental Health Counselor (LMHC) - Professionals that hold a master's degree in counseling or another closely related field in behavioral health care. Although their scope of practice varies, LMHCs are generally qualified to assess, diagnose and treat mental and emotional conditions and addictions.

Licensed Marriage and Family Therapists (LMFT) - Master's level professionals trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems.

Licensed Practitioners of the Healing Arts (LPHA) - Term that includes physicians, nurse practitioners, physician assistants, registered nurses, registered pharmacists, licensed clinical psychologists, licensed clinical social workers, licensed clinical professional counselors, and licensed marriage and family therapists.

Medication-Assisted Treatments (MAT) - The use of medications, in combination with counseling and behavioral therapies, to comprehensively treat substance use disorders and provide a whole-patient approach to treatment that includes addressing the biomedical aspects of addiction.

Medical Necessity Criteria - A definition of accepted health care services that involves diagnosis, impairment, and intervention. Medical necessity in Los Angeles County requires that individuals have at least one diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders. The service must also meet a recommended level of intervention consistent with the current edition of the American Society of Addiction Medicine (ASAM) placement guidelines, which include a consideration of biopsychosocial severity.

Motivational Interviewing (MI) - A type of evidence based practice and clinical interviewing approach that is a directive, patient-centered couseling style designed to elicit behavior change by helping patients to explore and resolve ambivalence towards change.

Opioid Treatment Programs (OTP) - Treatment programs that provide opioid treatment, including the use of medication-assisted treatments such as methadone and buprenorphine, and comprehensive

medical, psychosocial, and addiction treatment for opioid-dependent individuals in a therapeutic environment.

Progress note formats: SOAP, GIRP, SIRP, or BIRP - SOAP (Subjective, Objective, Assessment and Plan), GIRP (Goals, Intervention, Response and Plan), and SIRP (Situation, Intervention, Response and Progress), and the BIRP (Behavior, Intervention, Response and Plan) are specific methods of documentation that describe the format and content of progress notes to ensure communication and monitoring of patient interactions.

Quality Improvement (QI) - The planned and systematic activities that are implemented in order to ensure that the quality requirements for a service is fulfilled, with the greater goal of measurable improvements in health care services. The QI program is responsible for ensuring that the provision of substance use disorder services aligns with the SAPC's organizational mission and goals, and that services follow a standard of clinical practice consistent with medical necessity, best practice, and level of care guidelines described by the American Society of Addiction Medicine (ASAM).

Quality Improvement Project (QIP) - A provider-level project that follows the Continuous Quality Improvement model in order to identify and quantify issues or problems, and subsequent interventions, with the goal of improving care or services.

Performance Management - The strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results. Ideally, these practices should be integrated into core operations, and can occur at multiple levels, including the program, organization or system level.

Recovery Support Services (RSS) - Non-clinical services that foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals.

Risk, Need, Responsivity (RNR) - An evidence-based practice framework that emphasizes that criminal justice agencies should match offenders to services and programs based on their risk and need factors.

Screening, Brief intervention, and referral to treatment (SBIRT) - An evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence of alcohol and other drugs.

Substance Abuse Prevention and Control (SAPC) - The Los Angeles County agency responsible for leading and administering a full spectrum of prevention, treatment, and recovery support services for County residents.

Standardized Documentation - A structured method of clinical documentation that ensures an efficient way to organize and communicate with other providers. Examples include the SOAP, GIRP, SIRP, and BIRP progress note formats mentioned in this document.

Treatment Improvement Protocol (TIP) - A series of best-practice manuals for the treatment of substance use and other related disorders. The TIP series is published by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services.

Young Adults - Defined as young individuals between the ages of 16 and 25 who have unique service challenges due to their developmental stage and transition from adolescence to adulthood, some of whom may have received services from the adolescent service system and may need continued services and supports from the adult system

Utilization Management (UM) - The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control